NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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TUESDAY
APRIL 19, 2016

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Jennie Chin Hansen and Nancy Hanrahan, Co-Chairs, presiding.

PRESENT:
JENNIE CHIN HANSEN, RN, MS, FAAN, Co-Chair
NANCY HANRAHAN, PhD, PN, FAAN, Co-Chair
CHRISTINE AGUIAR, Association for Community Affiliated Health Plans
GEORGE ANDREWS, MD, MBA, CPE, Humana, Inc.
ELIZA BANGIT, JD, U.S. Department of Health & Human Services
GWENDOLEN BUHR, MD, MHS, Med, CMD, AMDA - The Society for Post-Acute and long-Term Care Medicine
MADY CHALK, MSW, PhD, Treatment Research Institute
JAMES DUNFORD, MD, City of San Diego EMS*
ALINE HOLMES, DNP, MSN, RN, New Jersey Hospital Association
K. CHARLIE LAKIN, PhD, National Institute on Disability and Rehabilitation Research
ALICE LIND, BSN, MPH, National Association of Medicaid Directors
THOMAS LUTZOW, PhD, MBA, iCare
MICHAEL MONSON, Centene Corporation
KIMBERLY RASK, MD, PhD, Alliant Health Solutions

E. CLARKE ROSS, DPA, Consortium for Citizens with Disabilities
GAIL STUART, PhD, RN, Medical University of South Carolina
GREGG WARSHAW, MD, American Geriatrics Society
JOAN LEVY ZLOTNIK, PhD, ACSW, National Association of Social Workers

NQF STAFF:
JANINE AMIRAULT, Project Analyst
MEGAN DUEVEL ANDERSON, Project Manager
SHEILA CRAWFORD, Administrative Manager
ANN GREINER, Vice President, External Affairs
MARGARET McGINTY, JD, Senior Manager, Public Affairs
DEBJANI MUKHERJEE, PhD, Senior Director
ELISA MUNTHALI, MPH, Vice President, Quality Measurement
ERIN O'ROURKE, Senior Director
SARAH SAMPSEL, MPH, Senior Director*
MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:
JENNIFER BARON, Centers for Medicare & Medicaid Services*
VENESA DAY, Centers for Medicare & Medicaid Services
CAROLYN MILANOSWKI, Centers for Medicare & Medicaid Services*
PAUL PRECHT, Centers for Medicare & Medicaid Services*

*** present by teleconference**

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(9:03 a.m.)

CO-CHAIR HANRAHAN: Welcome, everyone. My name is Nancy Hanrahan. I am a co-chair of the committee. I have been working with NQF for -- we will wait for a second.

MS. ANDERSON: So, while we are waiting for a few more technical assistants, operator, can you give the opening announcements to the people on the phone that we are going to start the meeting?

OPERATOR: Today's call will start momentarily.

CO-CHAIR HANSEN: Operator?

OPERATOR: Yes, ma'am, you may begin.

CO-CHAIR HANSEN: Thank you.

CO-CHAIR HANRAHAN: So, I think we are all set. Thank you. Thank you for being here.

It is just a delight for me to see people face-to-face. Phone calls are one thing and we do some work done but it is really, this is where it is going to happen. So, welcome,

everyone.

Jennie?

CO-CHAIR HANSEN: Yes, thank you. I am Jennie Chin Hansen. I am the co-chair with Nancy Hanrahan and I am delighted to see you all.

Just right off the bat, for how many of you is this first in-person face meeting? Okay, it looks like we have four of us in the room. And anybody else on the phone call for whom this is a first-time meeting?

So, we have the pleasure, as Nancy mentioned, to both see you as well as be with you during our once a year in-person meeting that we have. And as you can tell, the agenda is chock full and some of the preparatory work that many of you participated in is helping to, frankly, define some of the areas that we will go into.

And one of the things that strikes me, I am making a little bit of a commentary before we get into the content. I have had just the pleasure this past week of returning back from Scandinavia. And it was meeting of the

International Group for Quality and Safety in Healthcare. I happen to be on the Board on the Institute for Healthcare Improvement. So, this whole aspect of improving care is something that is obviously very core to the organization's sense of both safety and quality.

Something I was really struck about, and I think it brought me back to this meeting, is when there were 3,500 members who attended this international meeting and I could not put a little meter on the degree of enthusiasm people had for the idea of improving safety and improving quality of care.

And just looking and feeling that kind of enthusiasm and knowing kind of the intensity of what we are facing with the work that we are, along with the quality improvement work of the mission of NQF, the sense of how do we get to what is real important and something that we know will make a real difference in the lives of the beneficiaries and the consumers that we are a part of caring for.

And so one of the things that we would like to do that is built into the agenda is toward the latter part of tomorrow afternoon is an opportunity for all of us to really think about what is the role that we might be playing. Those of us who come together for many years and those of you who are newly joining us, we all know that this was kind of a new constellation of work, having a population defined instead of saying a provider or an institution, or post-acute care is a very concrete way. What is it that we can do to make this valuable?

I have joked -- I saw Alice Lind, who was the previous chair of this committee, that the whole question of what is this all about ultimately. And I think of three different areas: one is the whole aspect of accountability; and performance, performance that leads to payment; and then also improvement. And for those of you who were on the phone this last time we met, the Institute of Medicine has recently, I think within the past six weeks, come

out with the report on population health and what about measurement in population health. And I think it has some real germaneness to our work here.

So, as we do what we are charged to do, and that is operate under the aegis and the mission and purpose of the NQF and looking at the measures, endorsed measures, measures that people can use for both the Family of Measures and then what we call as the kind of the guiding Starter Set. And what about that big area that a lot of us, frankly, have been chomping at the bit for, whether for years or for those four of you who have joined us newly, what is going to make a difference for this population that is common in definition only by their economic status?

And so this is one of the areas that I think we have an opportunity to, after we go through the day and a half of work that we will be going through, to think about strategically what is the role in place and focus of this committee to continue to carry the ball so that

we do justice, frankly, to the populations that we are committed to making sure that quality is better, that measures are done well, that providers, as well as health systems themselves, can do this with the most effective targeting, so that we can get some results.

So, that is a preface. As I said, I was just so delighted to see the huge joyous energy that people had. And so I was thinking, how can we make that possible for measurement in quality here in the United States, in a way that we can do something similar by spending our time well, focusing on what is important, making it important from the eyes of the person who is receiving the care in partnership with providers. How can we make that kind of difference?

So, I just wanted to set that frame. And for some of the long-termers here, knowing that we have been trying to define an area and have a focus on topics that typically have not been within the purview of healthcare.

We have two guest speakers, tomorrow

later on. One of them is Alice Lind speaking about her experience and work now working on the state level in the State of Washington. We also have a Ph.D. social worker from Rush University who is going to be speaking to us on care coordination.

If you have had a chance to look at the slides in advance, there is one slide there that I think is very, very telling and it is a graphic to say that 20 percent of a person's health is based on clinical issues. Another 20 percent is based on genetic aspects. But 60 percent is this stuff that we normally don't measure. So, I think that is very important for us to kind of put as a context to why our work is so difficult. Because when we work with our Starter Set and available endorsed tools, they are actually about that 20 percent, while we are looking at the health of a person who is 100 percent and many other factors that we don't do.

So, let us move along with this. And the three major themes that we have are first to

do our annual work to the Family of Measures and to review what I mentioned earlier about the Starter Set. And with that, what are the priority issues for dual eligibles relative to multiple chronic conditions? We will hear very soon from our representative from CMS because this whole focus of MCC, multiple chronic conditions, is now a major theme by CMS and by virtue of that, we will integrate that into our work.

And then tomorrow, in particular, we will look at the linkages to the community, as well as hearing from related NQF projects from some of the committees that a few of you are cross-linkages to.

So, I will now pass this on to Janine to do roll call.

MS. AMIRAULT: Hi, everyone. So, I am just going to conduct a quick roll call. So, if you could, just state that you are here when I call your name.

Jennie Chin Hansen.

CO-CHAIR HANSEN: Present.

MS. AMIRAULT: Nancy Hanrahan.

CO-CHAIR HANRAHAN: Here.

MS. AMIRAULT: Susan Reinhard.

(No audible response.)

MS. AMIRAULT: Just a note, we are not expecting Susan in person today.

Gregg Warshaw.

MEMBER WARSHAW: Here.

MS. AMIRAULT: Christine Aguiar.

(No audible response.)

MS. AMIRAULT: Michael Monson.

MEMBER MONSON: Here.

MS. AMIRAULT: Clarke Ross.

MEMBER ROSS: Here.

MS. AMIRAULT: Cheryl Irmiter.

(No audible response.)

MS. AMIRAULT: We also are not expecting her in person today.

Jette Hogenmiller.

(No audible response.)

MS. AMIRAULT: George Andrews.

MEMBER ANDREWS: Here.

MS. AMIRAULT: Thomas Lutzow.

MEMBER LUTZOW: Here.

MS. AMIRAULT: Alice Lind.

(No audible response.)

MS. AMIRAULT: Joan Zlotnik.

(No audible response.)

MS. AMIRAULT: Aline Holmes

MEMBER HOLMES: Here.

MS. AMIRAULT: Mady Chalk.

MEMBER CHALK: Here.

MS. AMIRAULT: James Dunford.

(No audible response.)

MS. AMIRAULT: Charlie Lakin.

MEMBER LAKIN: Here.

MS. AMIRAULT: Ruth Perry.

(No audible response.)

MS. AMIRAULT: Kimberly Rask.

MEMBER RASK: Here.

MS. AMIRAULT: Gail Stuart.

MEMBER STUART: Here.

MS. AMIRAULT: Aliza Bangit.

MEMBER BANGIT: Here.

MS. AMIRAULT: Venesa Day.

(No audible response.)

MS. AMIRAULT: And Deb Potter. Deborah, are you on the phone?

(No audible response.)

MS. AMIRAULT: And Gwen.

(No audible response.)

MS. AMIRAULT: Just before we start, I have a few notes. If you could please turn your cell phones to vibrate or silent. We understand that you have other obligations. So, feel free to use the space just outside, where you picked up your name tags if you need to make a phone call.

And for workgroup members on the phone, please simply ask it in the queue and we will let you know when it is your turn to speak.

You can use your tent cards here, to indicate that you would like to speak and we will let you know when it is your turn.

Please be sure to speak into the

microphones. It is just very important, as everyone on the phone will also be interested to hear what you have to say. And the staff also uses the recordings and transcripts to make sure that we accurately reflect the views in the room.

Public comments are spaced periodically throughout both days of the meeting. We invite commenters to share their thoughts during these commenting times personally by coming to the microphone or over the phone, by letting the operator know that you would like to make a comment.

We also encourage commenters to submit comments over the chat at any time throughout the day. We will directly share them with the workgroup and ensure that they are recorded.

Bathrooms are past the desk where you checked in, near the elevators. You just take a right down the hallway.

Breakfast and lunch are provided to our group members and participating NQF staff.

We will be using voting tools

throughout the day. Please participate in the practice round that we will do now. In this practice round we are just taking a poll of anyone interested in going to dinner tonight, 6:30 at Georgia Brown's. And to vote, you just take your clicker here and you can see the voting screens are here on the sides. So, the polling is open. So, if we could just get a poll of anyone interested in dinner tonight. And just point it here at me. Thank you.

MEMBER BUHR: And the other thing I will say about the clickers. It is not like Chicago, where you vote early and often. When you vote once, no matter how many times you press, it is okay. And sometimes when we are looking to make sure we have all the votes, we may be one shy and Janine may say please vote again. It is okay, it is not double counting it. So, just one thing about the clickers.

MS. AMIRAULT: Just as one more reminder, organization and subject matter experts are asked to vote. Federal representatives are

encouraged to participate in all discussion but are requested to abstain from voting.

So, if you haven't voted for dinner tonight, just go ahead and point it at me. It looks like the clickers are working.

MS. ANDERSON: Thanks, Janine. This is Megan Duevel Anderson. I am so excited to see everyone here today. And for those of you on the phone, thank you very much for joining us.

For workgroup members on the phone, please do speak up if you would like to join the queue. And public, thank you very much in advance for your comments.

I would like specifically to give my appreciation to the co-chairs and the teammates, and everyone for joining us today. Sheila, who is supporting us, Janine, Debjani, and Marcia and Elisa who are in this room.

I am going to turn it over to Debjani to also welcome the group.

DR. MUKHERJEE: Hello, everybody. My name is Debjani. I am new to the Duals

Workgroup. And I am excited to be here. I have spoken to a lot of you and emailed a lot of you. So, it is nice to put a name to a face finally.

And at this point, I would also like to welcome our federal partners from the Centers for Medicare and Medicaid Services, Medicare and Medicaid Coordination Office, Venesa Day and Carolyn Milanowski.

And in the next section, our CMS colleagues will provide us with some thoughts and updates on the work around the duals population. We will also hear from Paul Precht about the CMS quality strategy and from Jennifer Baron about recent work with the financial demonstrations for duly eligible beneficiaries. And Venesa is here in person today. Welcome, Vanesa. And Carolyn, Paul, and Jennifer are on the phone.

MS. DAY: So, good morning. Thank you for having me. I just wanted to give some quick, very general opening things from CMS.

We really do appreciate the work that you have provided for us over the years. Every

year, we us what you give us kind of as our marching orders. And every year, we are reminded that there is more to do, more to be done, woefully stressed about what we need to get done and how we fit into all the moving pieces.

And I had some more elaborate remarks prepared but I just got here and sat down. I am not really ready. But I will say as I was driving here, I kind of thought about like how our work has changed and how our approach to the work has changed over the years. And so when we initially started this, we thought like oh, yes, we will just make everybody do what we want to get done. And so that didn't work, so we went back to the drawing board.

And then we said well, we will be kind of more collaborative, try to figure it out. And so that has worked more. But now we have added kind of ourselves as a hub and lots of tentacles.

And so as my colleagues start to talk through the different things happening in our office, I think the one thing we would like you

to keep in mind is that one, the work that we get from you guys in this process helps us to kind of filter in to other people's work and be smart about it, understanding where we need to be and what we need to touch and what works right for duals. And that has been a big part of our work, trying to get other folks to understand the importance of how our population impacts their work and also the measures that we want to see represented.

And we aren't as successful as we would like to see in a lot of ways but we definitely have made some progress.

When Carolyn talks, she is going to talk about a project that we have been working on for two years but really this last year is when we were able to get it to the finish line, where we were able to join with the Medicaid IAP, as well as Medicaid Home and Community-Based Services, LTSS components to put together a contract where we will do some measure development in areas that you guys have

highlighted for us as gaps. And that is some very important work that we are excited about over the next three years, trying to get more in-depth work from that.

But more immediately, we have produced or we will produce out of that contract two measures, behavioral health measures specified for duals and Carolyn, again, will give more detail about that work coming out of the measures. And we are really proud of that because it was really two years in the making.

And so now that is working, we are happy to have it done but that isn't all that we have done. When Jennifer talks, she will talk about our Managed Fee for Service Model and our Capitated Model. Really, we built our measure set on, for those two models, as you probably know, is from the work that you guys have provided. And we have changed those measure sets based on the work that you have provided and the information you have given us over the years.

And so thank you. We appreciate the

work and we have heard from you and we appreciate those calls and those emails and that direction that you have given us otherwise, in participating more broadly because we are really a small group and you ultimately are our way of being able to understand what really is happening and what direction we need to go in. So, thank you.

And I think I will turn it over to Carolyn.

MS. ANDERSON: Carolyn, are you on the phone?

MS. MILANOWSKI: Yes, I am. I think Jennifer Baron is going to go first because she is double booked today and would like to join her other meeting after she provides us her presentation.

MS. BARON: Thanks, Carolyn.

This is Jennifer. I am a senior advisor with the Medicare-Medicaid Coordination Office and I am actually based in Boston or I would have loved to have the chance to join you

in person today.

I just wanted to provide a really brief update on the status of the evaluation for the initiative under the Medicare-Medicaid Coordination Office, both forth the Financial Alignment Initiative and also briefly for the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. And this will just be more of a process and status update than reviewing the result included in those reports. Though, certainly, if you have any questions about the results, please feel free to be in touch and I am happy to follow-up also together with the Innovation Center folks who directly oversee our evaluations.

When I talked with Debjani about this session, I said something like I am sure you guys aren't spending all of your free time reviewing these 200 plus page evaluation reports for our demonstrations. And she said you know, actually, they are. So, I knew this was a group I could get along with.

And I understand you may also be hearing more from Alice Lind later in the session about some of the early Washington results as well.

But we have recently released three evaluation reports publicly. Two were for the state demonstrations under the Financial Alignment Initiative and one was for the Nursing Facility Initiative.

The Nursing Facility Report was the third annual report for that demonstration and that initiative, just for anyone who might not be familiar, CMS partners with organizations in seven different states and they are implementing clinical and educational interventions to reduce hospitalizations and potentially avoidable hospitalizations in nursing facility settings. And that report covers the second performance year for that initiative, which was 2014. We released it in early February.

And I guess I know I said I wasn't going to focus on results but I will say now that

overall, the results were good. RTI is the evaluation contractor for that initiative and did find a more consistent pattern of positive effects in 2014 than in the previous year, although the results varied a little bit across the seven sites that are implementing the intervention.

The other two evaluation reports that we have released recently were in January and those were both for the state demonstrations under the Financial Alignment Initiative. The first of those reports is an issue brief and it provides an update on the status of implementation for the seven demonstration states that started by May first of 2014 and those were California, Illinois, Massachusetts, Minnesota, Ohio, Virginia, and Washington.

And the report includes mostly qualitative information. There is some enrollment data in there but the qualitative information came largely from in-person site visits that RTI conducted to each of those states

and also engaged in some follow-up with the states with other stakeholders and with CMS.

So, for those of you who have seen that report and may be following the demos under the Financial Alignment Initiative, you probably didn't see too many surprises in there. It talks about the successes of getting the initiatives off the ground, which was no small accomplishment in all of the prep and the stakeholder engagement that went into that. And it talks about the main challenges being the time and the resources needed to implement those demos and in particular, states. And to some extent, the plans that are participating in the Cap Model demos, getting up to speed on the Medicare requirements.

The second evaluation report for the Financial Alignment Initiative that we released in January was an issue brief summarizing the early, early results for the first performance period for the Washington Managed Fee For Service Model demonstration. And we note that we called

it an issue brief, rather than an actual report because there will be an annual report upcoming that we are planning to release this year, actually, that will have a lot more detail and include additional qualitative and quantitative information and further discussion of the data and what the results actually mean.

So, the issue brief that we released included some enrollment information, some information on what the demonstration eligible population looked like, demographics, focus group results which were actually really good, some early descriptive results on utilization measure and preliminary Medicare savings results.

And so as I mentioned, overall, those results generally look good, although for the utilization data, in particular, I would just point out that the comparison group data were not included in that issue brief. They will be in the annual report.

So, while the descriptive data indicates some encouraging trends in the demo

group, it is also possible that the comparison group trends could be different or could be better.

So, in terms of next steps for the evaluation, for the Nursing Facility Initiative, we expect the next annual report to be posted on roughly the same schedule as this one was. So, that would be early 2017. And you also may have heard that we recently announced a second phase of that initiative that adds a payment reform piece to the clinical and educational interventions that are currently underway under Phase I of the initiative. And so we will be procuring an evaluation contractor for that second phase of the Nursing Facility Initiative as well.

And then for the Financial Alignment Initiative, we are really excited to be able to release the first annual reports for some of those demonstrations this year and those will be for the state demonstrations that started in 2013. So, those are Washington, Massachusetts,

and Minnesota. And RTI, who is the evaluation contractor there, is also beginning work on the annual reports and their related evaluation and measurement activities for the demos that started the following year, so in 2014. And we will expect to start releasing the reports for the 2014 states next year and that will likely be on a staggered basis, just because there are a number of those.

And we will be making all of those reports publics. The three reports that I just mentioned are posted on the MMCO website. I would be happy to share the link. If you need any help finding it, please let us know. And I am also happy to take any questions now, if there is time but please don't hesitate to reach out if you have any questions after the session.

CO-CHAIR HANSEN: Thank you very much.

Do any of the committee members have any questions for our CMS colleague?

Okay, if not, I will turn this back over to Venesa to acknowledge the next speaker.

MS. DAY: Sure. Carolyn?

MS. MILANOWSKI: Yes, I am here.

Hello. This is Carolyn Milanowski. I work on the Colleague Team in the Medicare-Medicaid Coordination Office under Venesa's leadership. I am glad to hear Bernie Sanders is in the audience, right from the Vatican to the MAP Duals Workgroup. Was that him on the call that I heard?

I wanted to provide an update, as Venesa said, on the CMS measure development contract that we are currently working on. So, as you probably know, the Medicare-Medicaid Coordination Office and the Center for Medicaid and CHIP Services have collaborating on a measure development contract to fill measurement gaps for Medicare and Medicaid enrollees and adult Medicaid enrollees. It has kind of a long name. It is called the Quality Measure Development and Maintenance for CMS programs serving Medicare and Medicaid enrollees and Medicaid-only enrollees.

CMS announced the project when it was

awarded to Mathematica in the fall of 2015. It is a three-year contract and for MMCO, the contract requires the development of six measures that are specific to the dual population, as Venesa said, two in each year of the contract. And for the Medicaid Innovation Accelerator Program, it requires 12 measures to be developed, four in each year of the contract.

And then separately, the contractor is also required to complete testing of 13 MLTSS measures for CMCS, which have been developed under another contract. So, this seemed to be sort of a natural fit in this contract. And those include measures such as an assessment composite, shared care plan, and functional status assessment, to name a few, all of which we think are relevant to duals and just sort of seem to fit under the contract.

So, I'm sure you are aware of the priority areas of development under the IAP program, substance use disorders, physical mental health integration, beneficiaries with complex

needs or sometimes called super utilizers and community integration/LTSS.

Of course, these areas are critical for duals as well. So, it makes sense to merge all of this work under one contract and even for measures to be developed that are common to both populations or even could be specified for both. So, we expect that almost all of the measures being developed or tested in this project will directly or indirectly benefit the duals population.

So, by the end of the contract, at least for MMCO, we should have at least six measures and likely more tailored specifically to the needs of duals and then we will have this larger set of measures that could be specified for duals in the future or can otherwise benefit duals, and certain types care.

So, for the dual measures, I just want all of you to know that the statement of work relied heavily on the recommendations of this workgroup and I have verbally shared your

insights with the contractor as well, not by individual name but as a group.

We emphasized the need for measures specifically designed for duals, for the needs of duals, given their complexity of healthcare needs and their multiple social stressors, and you know measures that matter to duals and their families and enhance their quality of life.

We highlighted the need for more outcome measures and person-reported outcomes. We also emphasized the domains of person- and family-centered care and care coordination, among others. But we also wanted to allow the contract and the TEPs enough latitude to make the recommendations based on their analysis of the environmental scans that were done and the literature review and the current state of the scientific evidence for individual concepts and, of course, the criteria of importance, feasibility, and usability.

So, the major milestones to date that you may be interested in are that first, there

were multiple environmental scans that were completed, I think all of them by the end of January. Two TEPs were recruited and formed under this contract. One, to advise on developing measures for the duals, the IAP priority area of community integration, LTSS, and the testing for the MLTSS measures. So, these three areas seem to be a good fit and had lots in common, given the large population of duals and LTSS.

The other test is for substance use disorders, physical and mental health integration and beneficiaries of complex needs. The duals LTSS TEP members met on April 13 for the first time to consider the candidate measure concepts. And then the IAP, what we call the IPA TEP is meeting this week.

So, the dual TEP is still in the process of completing a post-TEP survey and the results will be somewhere in the report to CMS due in early May. And then the IAP TEP report should arrive shortly thereafter.

And then from there, MMCO will closely coordinate the measure selection process with CMCS and other CMS components and you know assess how all of the measures will fit into our overall quality improvement strategies. We also plan to consult with ACL on their HCBS measure development contracts with University of Minnesota on HCBS outcome measures.

So, from there, we will post the measure information forms of the candidate measures to the CMS website for public comment and I can certainly give a heads up to the NQF staff when the public comment period is open, in order to pass on to you.

Once the measures are selected, the contractor will begin development two measures for duals, as we said, and four under the IAP program in the base year. And testing of the base year measures is scheduled to begin in late July, early August. So, we are on track currently. Hopefully, we will stay on track.

For the MLTSS measures, alpha testing

has begun with 11 planned and should wrap up this month.

And then each TEP will be convened again in September to consider measure concepts for the second and third years of the contract.

So, I just wanted to end by expressing CMS's great appreciation for your hard work, your insights and your guidance on the overall system transformation for duals. We cannot thank you enough for your contribution to this work.

Thank you also to the NQF staff for your incredible stewardship of this project for the past three years. You have all provided the foundation for much of our quality strategy for duals. And I know you know how important this work is to so many people.

So, we're as anxious as you all are to start implementing these measures that we are hoping to make a difference for duals and their families and caregivers.

So, I can open up now for questions or do we want to save questions for the end,

Debjani?

DR. MUKHERJEE: Why don't have Paul present and then we can take questions for everybody at the end?

MS. MILANOWSKI: Okay, sure. Thank you.

MR. PRECHT: Hi, this is Paul Precht. I am in the front office of the Medicare-Medicaid Coordination Office. My focus is a little bit narrower than either Venesa's or Carolyn in that I am working specifically on our quality ratings strategy for the Medicare-Medicaid plan. So, really, you know among the measures that you all work on, my focus is on measures applicable to capitated plans that deliver the full array of Medicare Part D and Medicaid services, including behavioral health and long-term services and supports.

Last November, we released a very high level roadmap to getting to a place where we could have star ratings for the MMPs that are analogous to the star ratings that exist now in

the MA and Part D program that would be consumer friendly to allow consumers to see, both on an overall basis as well as you know underneath that how the MMPs are doing compared to their other enrollment choices. And that could also be robust enough to serve potentially as a basis for adjusting payment.

Now, I want to caution here that we are not talking about layering anything on the existing payment system that exists now under the demonstration in which there are quality withholds. This is sort of to get us ready in the event that a model test is successful and it becomes a permanent part of the program and we walked through notice and comment regulation, putting out proposed rules to develop payment adjustments based on quality measures.

So, the question, the roadmap basically says we are looking and building on the existing MA and Part D rating that exists now that cover those services but a lot of what MMPs deliver, there aren't good measures. So, in

particular, LTSS, behavioral health, substance use disorder. So, we are relying very heavily on the work that Carolyn described in terms of measure development. For new measures that would be applicable to capitated plans that deliver those services but also looking at the exiting MA and Part D measures to make sure that those are specified in a way that are appropriate to duals, that they don't exclude cohorts of folks who are more prevalent in the dual eligible population but it might be appropriate to exclude when you are talking about sort of MA plans that focus more broadly on the Medicare population.

As we do this work, we have to have an eye towards what is practical to implement, in terms of reporting burden for plan, in terms of how it impacts their care processes for providers. So, I will just mention two aspects of that. One is we are very interested in how the Medicare-Medicaid enrollees, how they perceive the care that they get, the quality of life that they have as a result of the full array

of services, including the community support that they receive through those MMPs. And so to get that, you have to ask the beneficiaries their views. And so one way that that happens is through survey instruments. So, there exists now, as you well know, the CAHPS Surveys, the Health Outcome Surveys. There are additional surveys used in the HCBS population. There is also a lot of concern about overloading populations with surveys about the appropriate sampling when maybe only a segment of the plan population is receiving certain services like LTSS. So, that is something that we have to keep in mind as we work on measure development to make sure that the end result are measures that are not only good but that can practically be measured by the plan. The other aspect of that is the use of assessment tools or patient-reported outcomes, thinking about the value that they have both for measurement but also for informing how care is delivered but also being cautious about implementing anything that from on

high at the provider level affects how care is delivered, how the conversation between beneficiaries and their providers are conducted.

So, that all goes into the mix. It is a little, I am sure for stakeholders out there, this process may be a little frustrating because, as I said we released a sort of high-level roadmap in November but we are years away from implementing a rating system.

So, in the interim, we want to continue the dialogue and we also want to move step-wise to the extent we can in the direction of a rating system. And so the next thing that we expect to do is to release data on plan performance, on the measures they currently report on the Medicare Advantage and Part D world, as well as measures reported across all MMPs that cover additional areas not covered by the measures of the MA and Part D ratings and that with each successive year, the hope is to get that array more robust, both in terms of the measures reported but also in terms of how the

methodology that is used for comparison.

At its outset, it will not be as consumer friendly as a star rating but that is also part of the work that we will be doing over the succeeding years to improve it. And I think in the interim, it provides consumers with some information not now available, as well as other stakeholders to assess how the MMPs are doing on a host of measures.

So, I will leave it there in the hopes of providing some time for questions for myself or Carolyn or Venesa.

CO-CHAIR HANSEN: Thank you very much for those of you who have shared the information that each of you are working on in the sense of process and time frame.

We do have some questions here and I think that we could take probably two or three questions at most and then what we will do is have a chance to incorporate what you have brought to us in some of our slides that are coming up here.

So, I would like to call on Clarke Ross first and then Tom, second.

MEMBER ROSS: Hi, Carolyn. I have two questions for you. Clarke Ross with the Consortium for Citizens for Disabilities. The first question is who will be doing the testing of these new measures.

MS. MILANOWSKI: So, it depends on the measures that are chosen. I am sorry to not be able to give a precise response. But you know it will depend on the level of setting but we do expect at least some will be for plans. So, we will have plans to participate in the testing. So, yes, I'm sorry I can't say much more at this point.

MEMBER ROSS: Okay, the second question is Charlie Lakin and I continue to identify measures that are used by multiple states, for example, the National Core Indicators of the Personal Outcome Measures that have been used for almost 30 years. And I know they are in your environmental scan but did you incorporate

some of the core concepts of their measures into your testable measures?

MS. MILANOWSKI: All I can say at this point is we did incorporate those concepts in our statement of work. We have discussed those surveys and those are being considered but that is all I can say on those at this point.

MEMBER ROSS: Thank you.

CO-CHAIR HANSEN: Tom.

MEMBER LUTZOW: Yes, Tom Lutzow with iCare in Milwaukee.

You know we often question what is CMS thinking and, if you don't mind, I would like to ask you a forensic question along those lines.

It strikes me that to do what Paul wants to do in terms of reimbursing based on measures, the secret there is differentiation, separating good providers from bad providers, good plans from bad plans, and so on. But that differentiation doesn't necessarily support population health impact. And I am struck by the fact that the IMPACT Act has gotten everybody

organized around readmission prevention and I don't suspect that readmission prevention as a measure is going to be a good differentiator, in terms of quality necessarily but that is not its intent. It is to get population impact.

And so isn't there a need for more measures like that that organize resources, not expecting that if everybody gets good at it we are all of a sudden going to move it to the display measures status but we want to keep it in a star performance status across all providers. And diabetes is one of those population health issues that can't be impacted in piecemeal fashion. It has got to be attacked in an organized fashion, much like the way readmission prevention is being attacked.

So, is there tension within CMS itself in achieving population impact and then reimbursement differentiation at the same time? What is that? Does it exist and what is its magnitude?

MS. DAY: So, can you help me

understand like where you are going with you question? Because I am not sure I am clear on --

MEMBER LUTZOW: Well, I want to submit that we really won't put a dent in diabetes control by making only one sector of the healthcare system like plans or pick another one and expect to get anywhere with one sector having responsibility for it. All sectors have to be. And by that I mean hospitals, physicians, nursing homes, home health agencies, health insurance plans. Everyone has to be on that page. And hopefully, we will get good at it and hopefully we won't have a measure that ends up going to the display page because we can't let up on it.

So, I think we have something, a model with readmission prevention that actually does organize all systems toward the same end but there is relatively few of those.

MS. DAY: So, I think yes, I agree. We often talk about how I want to say the success of the work around readmissions. And you are right, it is kind of like all systems go.

Everybody is paying attention to it. We are measuring it in as many ways as we can and making sure we have it on the right levels in assessing who is touching it.

I think I also agree that it would make sense to try that type of approach in other areas that are important for population health.

I don't think I can speak to the broader CMS effort around something as specific as hypertension but I think the awareness is there, that the type of effort put behind readmissions is working.

MR. PRECHT: I would also add that I think in the measure development work there is attention given to trying to make the measures consistent and harmonious across different plan types and across different sort of levels on plans to the providers so that we are -- you know when we are getting all hands on deck to address these big issues like diabetes care or readmissions, we are not burdening providers with conflicting and duplicative reporting

requirements that get in the way of providing care.

But I think your point is well taken that on the areas that are sort of at the core of where we want to go with healthcare in terms of the major chronic conditions like diabetes or the problems that we have identified in readmissions or avoidable hospitalizations that they have a value in organizing and incentivizing the delivery of care that exists, I think that even if we come to a place where everybody is sort of topping out, which would be great.

So, that point is well taken and I appreciate you raising that.

CO-CHAIR HANSEN: Thank you. I know that there is probably far more discussion. I want to honor Nancy Hanrahan's last question before we move on.

CO-CHAIR HANRAHAN: So, thank you for the updates on what CMS is doing. It sounds like a lot of work and a lot of really good work. My question has to do with the data that you are

going to be collecting for each of these measures that you are developing. Is that data going to be available to anyone else outside of Medicare, Medicaid, or CMS for research purposes or even for purposes of doing population health studies? Because the big effort at this point, in my estimation, is doing a Watson-like population review so you can identify patterns at the population level and link multiple data sources in order to really get the full scope which is really, in my estimation, the biggest challenge for dual eligibles. Because as Jennie says, 60 percent of what we are dealing with has to do with very difficult measures.

And so I am interested in hearing what the plan is for really getting some external CMS help with this kind of data to really move this along.

MS. DAY: So, Carolyn, do you want to?

MS. MILANOWSKI: Sure, all of these measures will be available to the public. We will be reporting on them at various steps.

So, first, we will provide for public comment the measure information forms and the measure justification forms. And then, once the measure testing has begun, we will provide the measure testing reports. And then yes, ultimately, these will be available -- the data will be available to the public.

CO-CHAIR HANSEN: Thank you. I think we have one more question because we --

MEMBER MONSON: This is a question for Carolyn. So, how are you all thinking about on the MLTSS measures about taking advantage or are you thinking about taking advantage of the data that is being collected and the comprehensive needs assessments that are being done either in the fee for service system, by the case management organizations or in the MLTSS world by the health plans for those measures that the data doesn't exist in claims or the self-report from a CAHPS Study isn't necessarily going to capture the richness. I am just curious about how you are thinking about tapping into that data source.

MS. MILANOWSKI: Yes, good question. I don't think we know yet. We are not entirely sure how the testing will work out for that particular measure and then if and how we will use that measure. So, I'm sorry, I don't have much expertise in that area. I don't think we have anyone from CMCS on the line. It will start with them and we will see how it might be applicable to duals but I just don't know that yet.

CO-CHAIR HANSEN: Well, thank you to our CMS colleagues for giving us a glimpse of different bodies of work. I think what we have heard are some concerns to make sure that they have some alignment on a key level. One is to existing databases to conditions so that is not one-off and the ability for us to use available but disjointed collect data that currently exists to think about this.

So, we appreciate very much so Venesa, having you and your team be able to give us some glimpses and some heads up for us relative to

things that we might have to think about as a way of pointing out elements that we may have some concern.

So, thank you very much to our CMS colleagues here.

Our next thing is, since everybody seems to be here who is going to be physically here, I know we didn't do this at the very beginning and we are going to turn this next over to Debjani to talk about where we have been in the past five years.

As you are speaking, at this moment, could you just go quickly around to say your name and just the organization or the specialty that you happen to represent, so as we hear you speak, perhaps people could have that in context?

MEMBER AGUIAR: Sure. So, I'm Christine Aguiar. I am with Association for Community Affiliated Plans, also known as ACAP. And so I represent the Medicare and Managed Long-Term Care Plan. So, we have D-SNPs, the majority of which are integrated, then Medicare-Medicaid

plans.

And our plans constitute, depending on the month, between 25 percent to 30 percent of enrollment in the Financial Alignment Demonstration.

CO-CHAIR HANSEN: Thank you.

MEMBER HOLMES: I'm Aline Holmes. I'm Senior Vice President for Clinical Affairs for the New Jersey Hospital Association here as a representative of the American Hospital Association. Thank you.

MEMBER WARSHAW: Hi, my name is Gregg Warshaw. I am --

MS. ANDERSON: Gregg, your mic is not on.

CO-CHAIR HANSEN: Please make sure your mics are on when you introduce yourselves. Thank you.

MEMBER BANGIT: Hi, I'm Eliza Bangit. I'm with Administration for Community Living at the Department of Health and Human Services. I am also the government task lead to the HCBS,

NQF's HCBS task order and also the quality lead at the Administration for Community Living.

MEMBER LAKIN: Hi, I'm Charlie Lakin. I am twice retired, once as Director of the Research and Training Center on Community Living at the University of Minnesota and once as Director of the National Institute on Disability and Rehabilitation Research.

MEMBER ROSS: Hi, I'm Clarke Ross. I work for the American Association on Health and Disability but I am here representing the Consortium for Citizens with Disabilities, which is 113 national disability organization focused on public policy work here in D.C. founded in 1973.

MEMBER CHALK: I'm Mady Chalk. I'm Senior Policy Advisor to the Treatment Research Institute and working actually with CMS on the IAP measures.

MS. CRAWFORD: Good morning. My name is Sheila Crawford. I'm the Administrative Manager for our Quality Measurement Department

and I am here to assist the Duals Team with their meeting this morning.

MS. AMIRAULT: Hi, again. I'm Janine Amirault and I am the Project Analyst on the Duals Project.

MS. ANDERSON: Megan Duevel Anderson Project Manager for the Dual Beneficiary Workgroup. I am also going to see whether or not we have any workgroup members on the phone.

Not at this time.

CO-CHAIR HANSEN: Hi, I'm Jennie Chin Hansen and was the recent Chief Executive for the American Geriatric Society but my primary connection probably to this work is I was about 25 years with the original PACE Program in San Francisco called the On Lok.

CO-CHAIR HANRAHAN: Hi, everybody. Nancy Hanrahan. Currently, I'm the Dean of the School of Nursing at Northeastern University but my interest in my tenure here has been about five years working in these groups and seeing a lot of faces that I have seen for a long time.

But I have done mental health services research at the University of Pennsylvania for a number of years with a focus on people with serious mental illness, which are often the dual eligible groups. So, I feel like I also bring here my mother has Alzheimer's and I'm a consumer. So, I have am very strongly invested in how we manage these kinds of really complicated measures to ensure that we have a major transformation in our system.

DR. MUKHERJEE: Hi, my name is Debjani Mukherjee and I am the Senior Director for this Dual Eligible Beneficiaries Workgroup.

MS. GREINER: Good morning. My name is Ann Greiner. I am Vice President of Public Affairs here at the National Quality Forum.

MS. MCGINTY: Good morning. Meg McGinty, Senior Manager for Public Affairs here at NQF.

MEMBER MONSON: Hi, I'm Michael Monson. I have national product responsibility at Centene for our LTSS products, as well as our

financial alignment demonstrations. And we have LTSS products in seven states and MMPs in six states and are the largest LTSS plan and the second largest MMP. I'm thrilled to be here.

MEMBER BUHR: Hi, my name is Gwen Buhr. I am a geriatrician at Duke University and I am representing AMDA, The Society for Post-Acute and Long-Term Care Medicine.

MEMBER ANDREWS: Good morning. I'm George Andrews. I am a cardiologist and I serve as Humana's Corporate Chief of Quality.

MEMBER LIND: Alice Lind, Washington State Medicaid and I am here representing the National Association of Medicaid Directors.

MEMBER RASK: Kimberly Rask, I'm a general internist at Alliant Health Solutions.

MS. ANDERSON: Kimberly, you don't have to hold it down. Let's get the red light to come on.

MEMBER RASK: I'm not very technically savvy. Anyway, so I am the QIN-QIO for Georgia/North Carolina. We have two ESRD

networks and we also do Medicaid management work across the southeast.

MEMBER ZLOTNIK: Joan Levy Zlotnik. I am representing the National Association of Social Workers, where I am a Senior Consultant to NASW. And I guess I have been on the committee since the beginning.

MEMBER LUTZOW: Tom Lutzow. I am President of iCare. iCare is an original research and demonstration project funded by HCFA, now CMS, for testing the value of managed care for SSI individuals.

We have the distinct honor, I guess, of being the only plan in the country that was moved from a three and a half-star measure to a four-star measure by virtue of the scoring changes in the call letter, regardless of which method was used, categorical, index, or indirect standardization. And it turns out they picked categorical index.

So, we benefited from the fact that iCare serves duals, 70 percent of which are

disabled duals.

MEMBER STUART: Hi. I'm Gail Stuart. I'm the Dean of College of Nursing and a Professor in the Department of Psychiatry at the Medical University of South Carolina in Charleston.

Long experience in clinical research activities in relationship to behavioral health. And apparently, and actually for the last eight years, serves as President of the Annapolis Coalition on the Behavioral Health Workforce.

MS. DAY: Good morning. My name is Venesa Day and I am currently working at CMS with the Medicare and Medicaid Coordination Office. I am the lead for the quality work with that group.

CO-CHAIR HANSEN: Thank you very much. And Marcia, we are doing just a quick introduction of everybody around the table.

DR. WILSON: Quickly, Marcia Wilson. I am the Senior Vice President here at NQF for Quality Measurement. Thank you.

CO-CHAIR HANSEN: Well, thank you all.

It just gives us a sense of who is around the table. Sorry.

MS. MUNTHALI: Elisa Munthali, Vice President for Quality Measurement.

CO-CHAIR HANSEN: Thank you, Elisa.

So, let me turn this over to Debjani, who is going to have a chance to talk about where we have been in five years and the what is ahead.

DR. MUKHERJEE: Thank you. So, in the next set of slides what I am going to do is look at MAP at five years. And the goal to do this is to take a quick look at the achievements over the past five years before sort of move forward and discuss future directions.

So, in pursuit of the National Quality Strategy, MAP provides input to HHS on the use of performance measures to one, achieve the goals of improvement, transparency, and value; identify gaps in measure development testing, and endorsement; encourage measure alignment across public and private programs, settings, levels of analysis, and populations.

So, over the past five years, MAP has made significant strides in strengthening the use of measures within federal programs. And just to give you some statistics, there are over 1,543 measures that have been submitted for consideration by MAP for use in over 20 federal programs. And 50 percent of them have been process measures and about a third have been outcome measures.

However, guidance from MAP over the five years has promoted a change in the type of measures submitted for consideration. And in 2015, for the first time in MAP's history, more outcome measures were submitted for consideration than process measures.

And HHS has increasingly looked to MAP to provide up-front guidance prior to investments in measure testing as well. And we see more measures come through that are in development.

And in 2015, more than 60 percent of the measures submitted for consideration were under development and not fully tested. And less

than 30 percent of measures submitted were NQF-endorsed, due to their stage of development.

The next is a quick diagram that shows the change in the type of measures coming through over time. So, you can see there is a greater focus on transition of care, engaging patients in decisionmaking, as well as making care safer between 2011 and 2015.

So, in addition to changes in the performance measures that MAP has evaluated in the past five years, there have also been strategic shifts in the nature of quality initiative programs. As we all know, MAP was created by ACA, a landmark legislation that dramatically altered the healthcare landscape and ushered in an era of value-based purchasing.

And MAP has an important in considering measures for these new initiatives. HHS has continued to show its commitment to value-based purchasing best illustrated by the January 2015 announcement that it has set a goal of time: 90 percent of all traditional Medicare

payments to quality or value by 2018 through its quality initiative programs.

The landscape for federal quality initiatives has been continually evolving. And a good example is the Medicare Access and CHIP Reauthorization Act (MACRA) legislation. It repealed the Sustainable Growth Rate, tied payment to value versus the old system of volume, consolidated value-based payment modifier, physician compare, physician quality reporting system, Medicare and Medicaid electronic health record initiative into the Merit-based Incentive Payment System, the MIPS.

And what the MIPS will do, going forward, is evaluate how payments are distributed to providers based on the quality of care provided, resource use, meaningful use of EHR technology and clinical practice improvement.

Another such legislation is the IMPACT Act. And for time sake, I think we all know what the IMPACT Act is. We will move on to the next slide. That's fine.

And this is another schematic graph to show, over time, pay per reporting is going down and pay for performance and payment measures around measurement and quality are going up.

So, the next slide talks about the MAP and CDP alignment. MAP initially depended on the NQF CDP, the consensus development process to endorse measures and to evaluate testing and robustness of evidence before it came to MAP for consideration.

Over time, what happened is there is an interdependency between MAP and CDP which requires a seamless flow of information between the two process. Insight gained from MAP on pipeline measures are fed into the CDP process but as MAP sees more measures under development, this seamless flow of information is more important, so that any measure that is under development and considered by MAP is then picked up by the CDP process and then the CDP decision is funneled back to MAP. And the next diagram is a really good depiction of this seamless flow of

information where a measure that might be under development might come into the MAP process, be considered conditionally supported, be forwarded into the CDP process, and then the CDP process would analyze the robustness and the validity of the measures and it would sort of complete the infinity circle.

So, in the next set of slides, we will quickly go over the workgroup charge and the work to date, just to set a framework moving forward.

So, the dual beneficiary -- Dual Eligible Beneficiaries Workgroup provides cross-program input, primarily because there is no specific program, federal program for the duals population. They are represented in all and every federal program. The workgroup charge is to identify performance measures for use in dual beneficiary and subpopulations, prioritize measure gaps, provide strategic input for maximizing quality of life for Medicare-Medicaid enrollees. And this year, our focus is on individuals with multiple chronic conditions, as

well as community integration and connection to resources.

At the outset, the workgroup laid out a vision for high quality of care and set guiding principles. And since then, the work has evolved over the years. In 2015, MAP reviewed information to date about alignment and direct measure use experience, while considering recommendations. This year, the workgroup will refine priorities for measurement of multiple chronic conditions and dual beneficiaries as well as explore key issues related to healthcare linkages to the community and complete an update to the Family of Measures.

This slide shows our time line. We are here today, April 19th and tomorrow the 20th of the in-person meeting. And going forward, the milestones are the orange dots and it will be the draft report public comment and then, finally, approval through the coordinating committee and posting of the report.

So, this gets us to our first big

topic for the day, which is Multiple Chronic Conditions: Context and Emerging Policy. I will start off this presentation segment with a quick introduction and then we will hear from Ann Greiner, VP of our External Affairs and Meg McGinty, our Senior Manager of External Affairs at NQF, who will set the stage and context with the progress and current state of policy for dual beneficiaries, and the role of NQF, including recent legislature on the Hill.

So, who are the duals? They are individuals who are eligible for both Medicare and Medicaid, have a combination of complex clinical and behavioral issues, are socially disadvantaged and low-income. They are considered vulnerable, high need, also sometimes considered super users. They are a diverse population with respect to social, ethnic, and geographical representation. And just to give you some statistics about the finances, 20 percent of Medicare beneficiaries and one-third of spending. So, it is 498.9, so basically $499

billion and 14 percent of Medicaid beneficiaries, and one-third of spending. And it is $340.5 billion going in, basically $341 billion going in. So, given these dollar amounts, there is little known about the quality of care for this group.

Multiple Chronic Conditions are common.

MEMBER MONSON: Can I just make one point?

DR. MUKHERJEE: Sure.

MEMBER MONSON: I just think it is important on that previous slide we talked about they are typically considered vulnerable. I think we should be careful about that because I don't think that is true for much of the population. Just because you have chronic conditions or you might be a dual eligible doesn't make you necessarily vulnerable. And I think that we run the risk of kind of over-medicalizing the measures as a result of that.

CO-CHAIR HANSEN: Michael, I think

that is a great point. I think vulnerability may end up being defined in a broader way, such as economic vulnerability. And that is probably it. So, rather than just the medical definition, it may be a broader definition to economic security.

DR. MUKHERJEE: So, multiple chronic conditions are very common among Medicare-Medicaid beneficiaries. Seventy-seven percent have documented diagnoses across two or more condition groups of physical or mental illness; forty-one percent have diagnoses across four or more condition groups; and twenty-five percent have diagnoses across five or more condition groups.

And the fee for service per member per month costs are higher in beneficiaries with multiple chronic conditions than those without documented conditions. Expenditures were found to be twice as high for beneficiaries with two or more comorbid conditions and four times as high for those with five or more conditions.

The five most common co-occurring

condition groups include heart conditions, mental health conditions, anemia, musculoskeletal disorders, and diabetes. Two-thirds of individuals with any condition also have a heart condition and mental health conditions are the second most common co-occurring disease.

Some social and demographic status-related information for beneficiaries: women have a higher prevalence of chronic conditions, also have higher rates of three or more conditions; white non-Hispanic, African American, and Hispanic groups have the highest rates of four or more condition categories; and population under age 40 consistently has the highest proportion of mental health conditions and the lowest proportion of physical health conditions.

And with that background, frame-setting presentation, I would like to now turn the presentation over to Ann and Meg and welcome them.

MS. GREINER: Thanks so much. And thanks for giving us a chance to speak with you

this morning about the broader policy context in which you all are doing your work.

We are finding increasingly that we are having the opportunity to provide technical assistance to the Hill, as they work on legislation either to reform payment or reform the delivery system and understand that quality measures are a key building block of that legislation. So, we did provide some input on MACRA, on the IMPACT Bill, on the Chronic Care Bill, which we will talk about. But congressional staff are turning to us to understand what are the measures that relate to whatever policy they are focusing on, what currently exists, what might be coming down the pipeline, what are some of the barriers to getting to the measures that would be most appropriate for the policy aims that they have. And I think we are seen by both sides of the aisle as an important technical resource.

It was wonderful to hear the CMS presentation this morning and to really kind of

get a window into all that CMS is doing with respect to duals. And obviously, it represents a big change over the last number of years.

So, that has been very exciting but it is also daunting to really understand the complexity of the population that you all are trying to improve the care for. And I think the folks right now in the Senate, Senate Finance that are working on the Chronic Care Bill, are also beginning to understand how complex it is to try to improve care for those with multiple chronic conditions because they are certainly taking a long time to develop their policy.

So, let me just go through some conduct-setting slides and then we can talk more about what we are hearing on the Hill and how we are approaching our work.

You know giving this presentation today, I would really like to remain close with my colleagues here at NQF to really understand how your work is progressing because I think that can be helpful, as we meet with congressional

staff and give them a sense of the richness of the things you are working on and maybe help them evolve their thinking. So, next slide.

You know this but I think it is helpful to remember that programs established separate, different benefits, financing and what that means is we obviously have different program administration and different Hill staff. So, in the same office, you have got people who are charged with working on different programs and they don't necessarily talk.

Obviously, early on Congress realized that there needed to be more interaction with these programs and so began to think about ways that they are linked. Forty-four years later, so, that is 1972, 44 years later, we are still working on how do we better integrate. Next slide.

You know I think you could say we began some modest convergence with the PACE Program. And that is a typo. It should say 1997, when PACE got established nationally. And

we have an authority here in the room, so she is nodding her head. A truly amazing program. And I think we can be pleased that this administration saw how important it was to try to bring about more coordination between Medicare and Medicaid. And the ACA established the Medicare-Medicaid Coordination Office. I am sure that you are well aware of that. And also, you know this really using the $10 billion that are in CMMI to focus a number of demos on the duals population. Next slide.

So, you know, Debjani mentioned a number of these statistics but they really are I think what get policymakers' attention. You know why do we need better integration and focus? And obviously, as the dollars go up, the cost to serve this population goes up, it gets policymaker attention. And I think they also really understand how uncoordinated and duplicative and ineffective care is and also how complicated and not everyone in the duals population but at least some have -- there is a

lot of complexity in terms of the kind of care that they need. Next slide.

So, you know over the last number of years, and you all were just talking about this, we have seen the evolution of the PACE Program and I know recently, even more flexibility for CMMI to implement this program and that is very exciting.

I saw a blog that Slavitt did where he basically called out that we really need to put the PACE Program on steroids and within that said that they wanted to work closely with NQF because they recognized that they needed better measures and they really needed a very good quality strategy. So, we were excited to see that in his remarks. And obviously, the work of this committee is really important.

We heard this morning about the Financial Alignment demonstrations and that is very exciting.

Caveat here. When I wrote no evaluation yet, I know that there has been some

qualitative evaluations but I was thinking more of the big evaluations, where you have the quantitative data and really understand how the pilots have worked.

I did notice that there was a GAO report saying that we need more standardized measures so that we can better understand what is happening in these alignment demonstrations and you can compare one to the other. So, that was music to our ears. Next slide.

So, on the Hill, what kinds of things are we talking to staff about today? We have been involved with this Chronic Care Working Group. If you have been watching this for a while, you know that this is a particular interest of Senator Wyden's and this is his second go with trying to develop a policy to address folks with multiple chronic conditions which I know is a major focus for this committee.

The Chronic Care Working Group is being led right now by Senators Isakson and Warner and we have had a lot of conversations

with them. They had a hearing I think first back in 2014 and then they asked for comments to focus on this population in May of 2015 and then we provided comments then, again, in January of this year. And they are still working to process the hundreds and hundreds of comments that they received.

They have put out some working draft proposals, which maybe you have seen, 30 different ideas to improve care for those with multiple chronic conditions. It is a lot of different ideas. They are now working with CBO to score those different ideas and with CMS to understand how they might be implemented. It is kind of a cats and dogs -- there are some formatics for us in their proposal, very much focused on better care coordination. So, that is a goal.

They also think that we need to change our payment system to improve care for people with multiple chronic conditions and then they see the important role of performance measurement

to be able to spur improvement on multiple dimensions of care. Care coordination but also better cost control, more engagement of the patients and the providers in providing care, et cetera.

So, I just lifted up a couple of things in that document that has these 30 different revisions. They are focused on how can we, the Medicare program, that is, do a better job of providing services in the home. They suggest maybe we should be extending Independence at Home demonstration, have a better way to have hemodialysis therapy work. They have a number of ideas related to advancing team-based care, including there is a fee paid to providers for chronic care management. And this is a new experiment to see okay, if we pay primary care providers to help better integrate care, can we get better care integration. And I think the congressional staff have looked at that and said that is very promising but maybe that is not even enough to really help those that have multiple

chronic conditions and a lot of very complex needs. And so, we have suggested maybe we have an even severity, a higher rate for folks who have more complex needs.

Also with respect to advancing care coordination, they see the importance of integrating behavioral health. And so there is a particular interest in policies that integrate behavioral health. Obviously, you all think a lot about that.

There is, again, they put this under the rubric of advancing team-based care. Can we make special needs plans permanent? Periodically having to extend payment for special needs plan and not make them a permanent program means that they don't have kind of a long-term horizon, in terms of managing these patients. And so they are considering things like that. Obviously, that would be quite costly.

There is a number of things related to empowering individuals, everything from -- I mean I am telling you it is a smorgasbord -- digital

coaching, flexibility for MA plans to waive cost-sharing for patients who are in ECOs, more focus on pre-diabetes care. And given the recent news from the demonstrations that have been going on, maybe that actually will make it into the final legislation.

And then moving along, we have also been talking to folks on the Hill related to bills to leverage new technologies. And we heard from Senator Cassidy at our annual meeting last week that they hope that bills related to, and there is a number of them, new technologies that would support telehealth and remote patient monitoring will travel with this chronic care legislation. I think that is a big if, at this point.

There is a number of bills in Congress related to mental health, better integration of mental and physical health. Our consultants are giving a pretty low chance of being able to get through Congress this year.

And I would say all of these

provisions, while being worked on as you all know and are reminded of every single day, it is an election year. So, the closer we get to the election, the less likely it is that these kinds of bills will get passed.

Nevertheless, we work closely with congressional staff because they will be taken up again, if they don't move this year, in 2017 and we want to make sure we are helping them to understand the quality picture as they work on these bills.

And then finally, I put SES in there because it is obviously such a hot button issue and we hear about it almost every time we go to the Hill and it affects the special needs plans. It affects how payment related to vulnerable populations and I think, again, I don't think that the bills, there is a House and Senate version of the bill, is going to move this year but Congress is certainly under a lot of pressure to try to address this issue.

So, you know just last page -- I mean

last slide, please.

You know if you think about it, there is certainly a lot going on and a lot of resources being put into trying to find models of care that will improve care through the dual eligible. I was really happy to hear about resources going into development of measures that are more relevant to the dual eligible population. And having an administrative infrastructure in place that is focused on integration of those two programs in the dual population is wonderful.

I would say we need more of that integration on the Hill because you still have these silos and there is, obviously, more work to be done so that we can get to more integration and coordination.

So, let me open it up for questions and Meg and I are happy to provide additional insights. Thank you.

MEMBER ANDREWS: My question is -- it is a question but it is also a comment.

I think that we all recognize that there is absolutely great value in coordination of care, certainly, when it comes to the heavier medical coordination. We talk about developing measures and gaps where measure development needs to take place but, yet we haven't really addressed the process of how that coordination is going to take place. You have primary care, who knows their area of expertise and field of care. You have behavioral that knows their area of expertise but yet there are barriers on both sides in terms of how that information is going to flow on that person-centered care, so that that care would address the whole person, not just one aspect of that person.

As a cardiologist, I know my stuff and when I would be in the emergency room and have somebody come in in cardiogenic shock and it was from an antidepressant overdose, yes, I know how to handle shock but I don't quite know very well the drugs that are used in the behavioral field. The psychiatrists and the behavioralist do. And

they also don't know whether a drug is good or not good for a particular cardiac patient, if they don't know the full details of that patient's heart status and whether drug A is not going to affect the rhythm of the heart or drug B will affect the rhythm of the heart and cause heart block and need a pacemaker for that patient.

So, what I am trying to say is there is information that is critical to be shared but, at this stage, the way our system is regulatory, HIPAA-related protections, intentionally for good reason, they are, however, creating barriers to that free flow of information that is critical to that best patient care.

Patients, at the same time, persons are afraid, even if they are asked, to sign, to have information shared because, again, regulatory-wise and otherwise, we do not have protections against discrimination just because somebody has depression. And again, as a cardiologist I know if I have somebody who is

depressed, I know already they are not going to be as compliant in terms of what I say or do. So, their care is going to suffer.

So, I guess my question and a comment is, before we start creating and trying to find ways to measure performance improvements in this particular aspect of integration and coordination of care, maybe we should be thinking much more broadly, CMS-wise and government-wise, and regulatory-wise and consumer-wise. How can we create this ability to have the free flow of information and eliminating or having checks and balances to avoid any possible discrimination and have penalties when that occurs so that the patient and the doctor can do what they need to do.

MS. GREINER: I do have one comment about the patient privacy around sensitive information and actually this was addressed by one of our panelists at the NQF annual conference, Deborah Peel and she works on patient privacy issues. And she explained that in Europe

there is much more oversight of patient privacy issues in making sure that information is not used in a discriminatory fashion. I mean we don't know, because we don't have any data, as to how prevalent it might be that information is used particularly for sensitive behavioral health issues, in a manner that would be problematic for patients. We don't know how big a problem it is in this country.

But it was interesting that you did say that those frameworks are in place in Europe to guard against that and there are penalties if there is any issue.

So, on that particular issue, there are remedies and they exist elsewhere.

CO-CHAIR HANSEN: That is a great comment to think about how other countries are dealing with this. But I think the journey that you just outlined speaks to a very detailed granular way to talk about coordination and best care.

A process comment, at this point. On

our calendar schedule is the fact that we would have public comment at this particular time.

So, for those of you with tent cards up, we will do that but the operator will need to announce to any public members who want to make a comment, that this is their opening time.

So, we will have time for your questions. I just wanted to point out that this is the case.

Operator, could you open up the comment line for anybody who might have questions?

OPERATOR: Yes, ma'am. At this time, if you would like to make a comment, please press * and then the number 1.

CO-CHAIR HANSEN: Is there anybody in the line in the room?

OPERATOR: At this time, there are no comments.

CO-CHAIR HANSEN: There are no comments, then? All right.

So, why don't we --

MS. ANDERSON: And I am just going to ask Jim Dunford if you have joined us on the phone.

MEMBER DUNFORD: Yes, I have and I have no conflicts to report.

CO-CHAIR HANSEN: Thank you. We are so glad you could join us and we appreciate that you woke up extra early to join us.

Please do let us know at any time if you would like to get into the queue and I think Jennie is going to go around the room with people who raised their tent card.

MEMBER DUNFORD: Thank you.

CO-CHAIR HANSEN: Thank you. And we have two tent cards up. Joan and then Tom.

MEMBER ZLOTNIK: I just I guess maybe want to make a comment and I'm glad that Robyn Golden will be speaking tomorrow to us about care coordination because kind of harkening back to something someone said in the room earlier today, maybe it was Jennie, probably it was Jennie, about the 60 percent of needs that are not

medical or genetically related, in terms of people's healthcare needs, that the issues of sort of the care coordination sort of permeate every meeting I go to and I don't think it is necessarily a physician role. And if you look at examples like independence at home, some of them use social workers and many of them don't. And so looking at how social workers with care coordinator's roles can be enhanced and many of the CMMI innovation grants that are made actually use social workers. And I think in our last meeting, the folks from Oregon spoke about how they started out thinking they were going to use community health workers and ended up with MSW level social workers. So, I think it is really something to think about around some of the workforce issues, that when you integrate health and behavioral health, yes, clinical social workers or behavioral health providers but also social workers play many other roles in the healthcare system.

CO-CHAIR HANSEN: Thank you, Joan.

Yes, we definitely will hear more tomorrow on this.

Tom?

MEMBER LUTZOW: Yes, on this issue of adding measures to deal with multiple chronic conditions, I think there is opportunity certainly for the application of measures that stretch existing resources beyond where they want to go. And so those measures should be pursued. And I will give you an example. iCare members are in that 25 percent group that have six or more co-occurring conditions, on average. And our PMPM for medication is in the $800 a month range. It is so high that pharmacies can afford to do in-home pharmacy services. And so we have referred about a thousand of our members to a pharmacy called Hayat Rx. Hayat Rx actually sends pharmacists in the home. They can afford to do it because of the intensity of the medication regimen. They can afford to do it and do comprehensive medication reviews, med sync, a host of other things that help with adherence and

enable the member to avoid having to get up, get out and go to a pharmacy to take care of their medications.

So, there they are a measure stretching existing resources works but it won't work all the time. And as you apply measures, states always complain about unfunded federal mandates and counties complain about unfunded state mandates. I think you need to be careful about unfunded responsibilities that come with the application of measures.

So, yes, I would like to hold primary care resources responsible for follow to home and in-home services and out of office outreach but it is an unfunded responsibility.

And we need to take a real good look. And telehealth is an example of that. It is a ball being thrown back between Medicare and Medicaid and was it really savings. And we have to stop that ball tossing and take a look at -- make sure that we fund the expectation. In some cases, the resources aren't there to be

stretched.

CO-CHAIR HANSEN: I think that metaphor of unfunded delivery expectations on that. So, I just wonder Venesa, whether your team have any thoughts on as we look for these aspects. And right now, the one segment of funding my understanding is for care coordination is $43, $44 per contact and it is a limited amount.

So, any thoughts on how we achieve more integration and care coordination and the way funding exists now and how that relates to measurement and accountability.

MS. DAY: That is kind of like the million dollar question, it is so loaded. And I will invite my team, actually, to comment as well.

But I think that we are all striving to kind of get to a place where we can do all this great work and minimize the burden on everyone. I mean I wish we had some kind of great answer but I can say that it is a question

that we hear a lot. I don't know that I, myself, have thought of it from your perspective and I like that. And I will definitely take that back with the idea of unfunded responsibility because we do talk about, particularly in our work, about all the other things that go along with being able to treat our population. And I was actually talking to my daughter the other day about my own work and she was like well, I don't understand and all over the place. I said think about it. If you have someone and you are a doctor and you need to treat them, if they don't have a telephone, if they don't have somewhere to live, if they maybe don't have a family member, or if there is no way for you to reach out to them, how much harder is your job and your work?

And so what I hear in this conversation is just about that kind of unfunded responsibility because there is that additional work that you have to do, especially around this population.

And I think that we have programs,

certainly, that are trying to address that. I think there was just a grant released and forgive me if it hasn't been released, it will probably get -- but there was a grant panel that we were asked to be on for a program coming out of the innovation center that deals with kind of the idea of meeting the broader work. And I think a lot of the work that we do tries to get at that, maybe unsuccessfully but I don't have a great answer that nobody else around this table has kind of thought of already but I think it is something that we are all kind of working toward and certainly on several different levels.

CO-CHAIR HANSEN: I have four tent cards up. We will start with Mady. Then, we will go to Charlie, Michael, and Eliza.

MEMBER CHALK: A comment and an example about this unfunded business, unfunded expectations.

So, I mentioned earlier that I am working with CMS on the IAP measures. So, we are talking about, just to give an example, follow-up

after detoxification for people with substance abuse disorders. Detoxification is a medical benefit. Follow-up is a clinical benefit. So, you have got sort of -- already you have got problems about how you are going to follow these people. And this is for Medicaid beneficiaries, including dual eligibles.

The question arises, and I think this group needs to address it, too, about what we think measures are going to do. Are we creating some measures to drive change or are we simply measuring? The follow-up, we have no idea to get down to the granular level that George Andrews was talking about. Who is going to do the follow-up? Not a clue. Where does it happen? Does it emanate from the place that is doing the care; that is the hospital or the emergency room? Or are we supposed to have primary care reach out or substance use disorder treatment reach out? And there is no funding for it.

It becomes a very complex issue and all I am -- the reason I am raising it is some of

what we have talked about in this group are measures that may drive change if we begin to use them to focus that way, rather than simply measuring.

So, when we get to care coordination, I keep thinking, okay, what are we measuring there and can this group start talking about how that is going to drive what you are talking about.

CO-CHAIR HANSEN: Carlie.

MEMBER LAKIN: Well, my life experience has really been in long-term care and primarily home and community-based services. So, I kind of think about the world from the perspective of trying to measure outcomes, quality of life, the costs of home and community-based services.

I really appreciated Tom's comment about unfunded responsibility but I am also driven to think about actual responsibility. And I think, Mady, you pointed this out a little bit. We talk about measures around here all the time.

And NQF endorses measures that are viewed as valuable and valid and reliable. But less attention is really given to the system that need to be in place for these measures to mean anything.

You know we just don't talk about what kind of training people need to gather this data. We don't really talk about the implementation strategies, whether universal assessments or sampling that are needed to gather data that are useful. We don't talk about sampling ratios. We don't talk about universals. We don't talk about data management. We don't talk about who is going to analyze these data and present them in ways that they are going to be useful. We don't talk about how they are going to be actively involved in improving systems.

And you know I have had the chance to go around and see implementation of states with a couple of the long-term care measurement systems that have been developed. And I will tell you, they differ so greatly in the quality of the data

collection and the usability of the data that are gathered that if we don't get to that level, we have just listed a bunch of questions. You might want to ask somebody. But beyond that, I don't think we really have gotten to the depth of what is needed to really move quality among CMS programs.

So, that is my only thought as I listen to us talk about measures.

MS. GREINER: Our board has recognized this as an issue that we would like to try to at least begin to get more information on; that is, implementation experience so that it can help us to understand more about what happens when the measures move into the field. We do get some of that information but we need a lot more.

And so we will be doing some pilots, where we can get some more granular information about implementation. I think the other things that we think about is measures in isolation without understanding whether or not there is an evidence-based intervention also is problematic.

So, we have seen the biggest gains when you have an evidence-based intervention, you have got a standardized measure, and maybe even when you have a payment incentive.

And so I think we can't look at measures in isolation. We have to think about all these other factors and once we have a richer understanding of that, we probably will be able to identify the measures that are going to give us the best results.

CO-CHAIR HANSEN: Michael.

MEMBER MONSON: Thank you. To build on some of the comments that have been made, one of the things that we should be considering is that often these measures get designed based on the benefit packages of the programs. And one of the unique places that we sit at as the Dual Eligible Committee is that we can think about across the benefit packages.

So, for instance, if you think about individuals who are receiving LTSS services, it could be that they have COPD and the reality is

that the COPD is exacerbated because of the infestation in the apartment or the home that they have. But the measure that we might want to be looking at then is the evidence of pests and pest control, as opposed to the clinical outcome, not that the clinical outcome is not important, too. But I think that this interplay between the environmental factors and the social factors that are existing in people's lives that we are very much focused on from an LTSS perspective, will have direct downstream impacts into people's health impacts. And so if we think about the multiple chronic conditions, I just would encourage us to be thinking broadly about the determinant facts of that and how they interplay together.

CO-CHAIR HANSEN: Thank you. I think our later discussion about SES factors and how that is a backdrop context will be very helpful.

Eliza.

MEMBER BANGIT: Thank you. Actually it is more of a comment than a question. We are

talking about sort of the importance of care coordination and what are the things we could do to move forward. A couple of things came to mind specifically for the Financial Alignment demonstration. I know that that is, I believe, a core element, Venesa. I am speaking to Venesa and also the MMCO folks on the call.

You had mentioned, I think Carolyn had mentioned that there a couple of reports that may be coming out early next year, the issue briefs, the two issue briefs that you have spoken about. I think it would be really important or real interesting to see how care coordination is working in the financial, I believe the 13 Financial Alignment Initiatives, but more specifically in Colorado, which is a fee for service model. They do have regional care coordinators, which is I think the main element that changed in Colorado, in terms of how the Financial Alignment demonstration is working there. So, I think looking at their experiences and what data they are gathering and what it is

showing in terms of any improvements in quality, not only in the care services but quality of life of the beneficiaries who are the duals and the demonstration. So, I think that is just a couple of notes that is something to think about maybe for future reports that this workgroup may benefit from.

CO-CHAIR HANSEN: Thank you, Eliza, for pointing that out because, ultimately, if there is better integration of finances, there allows some flexibility within that as to how that money gets moved around by whoever the accountable entity will be. So, it will be of great interest.

I think we have one more question, Christine.

MEMBER AGUIAR: Yes, thank you.

I agree with a lot of the comments that we have heard. I could not agree with you more, Tom.

In addition, I think it is important to think about it holistically. So, measures not

just again for plans but for future service providers, et cetera.

We have been having a lot of conversations with our member plans about coordinating the care coordinators because there is responsibilities from the hospital systems, from the nursing homes as well. And so I think it is important to think not necessarily that the plans, and the hospitals, and the nursing homes have to have the same measures but that they are all not being duplicative but moving towards the same goal of population health.

CO-CHAIR HANRAHAN: So, it occurs to me, you know I like to think about images that we are trying to set up the dashboard on a car that we are driving when we are driving the healthcare. And if you drive in a car, there are certain very familiar parameters that are guiding you as you move along, right? You know there is the miles per hour. There is the stick shift and all of these parameters are focused around keeping you safe and efficient both in your gas

use and getting to the place where you want to go.

So, in a sense I think that what really is troublesome around these conversations for me is that we bounce between this very detailed individual level experience to the population level, which we just heard about, which I really liked the population level but the problem at the population level, especially in Congress is they start getting down into the weeds, instead of creating the car that is going to look different, no matter what community, family, individual. There has got to be an infusion of differences that we are never ever going to get to the place where we are going to be able to measure that level.

So, I really like what you presented because we are talking forward into this national conversation about measurement and how do we measure but if we get down into the weeds of that measurement and the detail around differences in communities. We are going to get distracted from

what I think is our job and that is how do we get measures that give us these same experience of miles per gallon, managing how fast we go. Those sorts of measures are really the measures that we should be really capturing at the national level.

And then let all of those individual PACE Programs, ACOs, the dual eligibles create the own at their level, the state level. They are always going to be the state versus the federal. We live with that and it is part of our democracy that I think is really, I believe that we want to encourage differences.

So, as we move forward, I would encourage us to be thinking about what are these drivers that we want to tag onto that we then will influence what kind of measures that we can determine in our dashboard as we move forward.

CO-CHAIR HANSEN: I'm going to, if I may, comment to Nancy's. And Tom, I will come back to you.

I think that your example of using that metaphor is a great one, Nancy. The ability

for us to, however, move through this murkiness when measurement, as we have historically known it, has been so clinically medically defined and now when we move to a whole other arena, we don't evidence-based history of even social. We have some components but to put it together in a holism is not the way healthcare has been traditionally framed. So, somehow we need to use metaphors like yours but the question I may pose back to NQA staff is whether or not other countries that have integrated social and medical care, are there ways that they are measuring that we just have not necessarily used here but could learn from? Because I saw in a couple of slides there was a discussion of Canada, as well as I forget what the Scandinavian country but is there a way to really think about that? Because right now we work with what we have.

The body of work that this group is going to be doing in the next day and a half takes existing measures, tweaking to some extent to kind of make a go of it, when we realize we

actually have moved to another country. So, how do we bridge that?

And then all these granular examples that cause great distress and really kind of deactivate the joy of really caring for -- that shift and are there some plans that NQF has?

MS. GREINER: Well, I was wondering if Nancy had been in our Board meeting because I mean you really summarized so well how the Board is thinking about how do we move forward that a recognition of trying to lift up the most important measures to help us understand how we are doing for a given population, rather than at the programmatic level so that you could say okay, how are we doing for a certain population.

Because we have seen that the field is asking for more guidance about what are the most important things that we should be focusing on. And so developing the criteria to get to those most important measures is something that we are going to be working on.

And in answer to your question,

Jennie, I don't know. We have been meeting with some folks outside of this country but it has been pretty episodic meetings and every time we come away saying wow, they have such insights, particularly related to integration between public health and medical and how they spend their dollars, not on health, on pop health. You know and we just keep scratching our head when we come away from those conversations. So, I think it is a really rich area for further inquiry.

CO-CHAIR HANSEN: Thank you. We'll have one more.

MEMBER LUTZOW: Yes, I have a suggestion to the issue. And no solution is common core.

I understand Marilyn Tavenner just came out with a blog complaining that there are too many measures. And of course we know what Donald Trump wants to do with common core on the educational side. But if there were a new domain in everybody's measure set, a common core domain that focused -- and let's make readmission

prevention part of that common core domain and add diabetes and some other things that are population health-focused, we would end up with collective impact and without excessively burdening anybody more than they are burdened now.

So, it may be that the solution is right in front of us. We don't need to take any measures away. Let's add another set of five that are common core.

CO-CHAIR HANSEN: Thank you, Tom. That is something to think about.

I will give the last comment back to Venesa at CMS.

MS. DAY: So, I really appreciate this conversation. Every year we leave here and I am always like we have this whole set of measures. I think last year it was like 54. And it really gives me anxiety because how did we get 54? How do we get anything moving on all of this in all of these different areas? So, a lot of what we do is trying to take what we get here and then

look around and see where else it exists and then try to infuse what we think about our population into what other people are doing, where we can. And that is a pretty difficult task.

And honestly, we have talked a lot about how to get out of that cycle because we want to have something that is real and meaningful for us because even if someone is using a measure that overlaps with us, it doesn't mean that they are using it in a way that is valuable for duals, in a way that we can use it.

And so this conversation around the common core, even your earlier comment about everyone pulling together around an essential issue, I feel like it would definitely, even from a process level, give us a way to direct a path forward that I feel like would be very effective.

So, and I think there are some measures that exist. We some repeated measures and I think maybe that might not be the way we want to go because I think last year in this group we kind of had this conversation about

seeing the same old measures, types of medical measures being used. But I mean, definitely, each agency has something that we could measure at a population level across the board and so that everybody, the ship is going in the same direction. It might be something definitely that we would want to talk more about.

CO-CHAIR HANRAHAN: I really appreciate you saying that, Venesa. I think it really kind of summarizes what we have just been talking about.

I also think that there is a new methodology that has emerged in the market and it has to do with data and how data gets used and how big the data we can process simultaneously to set up patterns. And the NQF conference focused on the reengineering of data and creating architectures that would give us the information we need that would define these core commons, which I think is really what we are seeking here is the core common.

So, you know I am going to register a

suggestion that we need to bring onboard to these meetings people that understand these kinds of ways, methodologies for developing measures and especially if this group, which I think is a natural focus group, that we look at the core common -- thank you, Tom, for that word -- and how that core common emerges on these databases or these data points we have got simultaneously all over the place.

So, not only do we need a core common but we need to refresh around what is the methodology that we are engaging to move into the future about measurement.

CO-CHAIR HANSEN: Thank you, Nancy.

Last opportunity for a comment from our colleague on the phone. Jim, anything that you would like to add?

MEMBER DUNFORD: Sure. This is terrific. I mean as the City of San Diego's Medical Director, I think of my patients as 1.3 million people today.

And I am looking across the entire

system. And one of the things that I see, whether it is acute disease or chronic disease is a lack of measures that reflect the adequacy of the governance process of the population itself and no award systems exist for doing the right thing on a population level. We have a trauma system. We have a heart attack system. We have a stroke system. Those are all acute diseases but there is money tied to a community having those systems because it does save money for Medicare patients. It does improve lives.

Now, we are moving to chronic disease. And again, we don't really have a governance system and I think what we really should be striving for on a national level, personally, is the definition of what is an accountable care community and reward those communities that ultimately establish them and then select tracer conditions that exemplify the types of systemness that we want. I think, again, I spent a lot of time thinking about super users. The most expensive people in my city are completely

disconnected, homeless, mentally ill, substance abusing. They spend the most money of all. And the lack of systemness is the number one problem that I have in terms of trying to coordinate their care.

And there are gaps between all of the providers that we have mentioned that really need to be filled. I use community paramedics because they connect the social workers who don't really exist in the spaces where these individuals actually resides. But is the systemness, to me, that needs to be rewarded at some point. So, I would just encourage us to continue to move this process and have measures that actually reflect and reward communities that actually get together, put their guns down at the door and think about how they are going to collaborate for the common good because a lot of these things cannot be designed by an individual accountable care community. They are really the fabric of the community itself.

CO-CHAIR HANSEN: Thank you very much,

Jim, for your eloquent summary of looking at this on a system level.

So, again, I thank everybody. I thank the CMS staff for being here and contributing to this, as well as our public affairs staff from NQF and the very, very thoughtful, as well as forward-leaning comments that many of you have done.

So, I am going to now pass this over to Debjani to be able to move us to the next section.

Thank you.

DR. MUKHERJEE: Thank you, Jennie.

So, the next section continues this discussion of overcoming barriers to measure development for multiple chronic conditions and we are running a little behind schedule so, instead of going through the slides, I am just going to summarize some of the issues that the slides talk about and then we can go dive into the discussion.

So, the main issue discussed in these

slides is data challenges. We don't have good data, whether it be clinical and/or behavioral. And it kind of ties into our discussion previously about big data and databases and data systems. And being a methodologist, I am really excited because there is another concept that comes along and it is skinny data.

So, big data are big databases, where you can get population level data and skinny data is actionable data on slices of the population. So, whether you are looking at a behavioral aspect of care or chronic disease management, either or data would be good at this point, since we don't have any and especially data that gives us a complete picture with the consumer at the center and takes into account their complex psychosocial issues.

We recognize that stakeholders in the arena are frustrated with the lack of progress towards priority measurement development and it is a challenge to overcome barriers to understanding and improving care needs. So, we

need data to improve care, to improve care we need data. It is sort of the chicken and the egg issue that we are facing.

So, in this slide, what we do is sort of look at some of the issues that the group has discussed already. We have looked at some measure gaps for quality of care and it has been an ongoing frustration that measurement hasn't caught up, the development of measurement, with respect to the number of gap areas. Also, there is the issue of resources and resources being devoted to bridge gaps and where is the resource going and how many gaps are being bridged, as well as barriers to measure development in complex populations.

So, the question to the group is how do we overcome these measure development gaps and barriers. What are some unique ways we can think about it or work around this lack of data issue? And what does ideal measurement for individuals with multiple chronic conditions look like or what should it look like? And who are the key

players or key sort of decision points? Or what is the tipping point?

MS. ANDERSON: I think I just want to also recognize one of Tom's earlier statements about the importance of measures that cross, cross different providers, cross different settings of care. And so I think that is a good place to start the conversation.

Is there a common core? Is there a common set of measures that should cross settings and potential providers? Is that a good solution or are there other ideas that the workgroup has?

CO-CHAIR HANSEN: Clarke and then Christine.

MEMBER ROSS: I would like to start with a common core is to focus on the beneficiary themselves. Three of our seven priority gaps that we developed in 2013 reaffirmed in 2014 and reaffirmed in 2015 are shared decisionmaking, beneficiary sense of control, autonomy, and self-determination, and community integration inclusion and participation.

So, rather than get into a discussion of whether diabetes is more important than high blood pressure or substance use disorder, to me, it is starting with the individual beneficiary, their experience, their quality of life, their expectation.

And then that means a lot of costs. So, the Council on Quality and Leadership and the personal outcome measures have been accrediting community-based organizations in the developmental disabilities and now recently in the mental illness field for almost 30 years. And when we tell the National Committee for Quality Assurance that an average audit, accreditation audit of personal outcome measures involves four days of interviewing the actual beneficiaries, a random sample of the beneficiaries. But health plans folks say, God, how much; four days? And they start multiplying the cost of surveyors. It is a lot easier just to -- whether people are on their blood pressure medicine.

So, this is expensive but if we really nod and say we all agree we should start with the beneficiary's experience and build out from the individual person, it means a different approach but it also, in my mind, would avoid some of these natural conflicts that we are going to have between disorders and conditions and medical and clinical and non-clinical.

And we do have an evolution of mechanisms and so on -- last comment. I was disappointed that the CMS folks, Venesa is not here right now, did not talk about the Medicaid Home and Community-Based Service Experience Survey in which we have roughly a dozen state Medicaid agencies who have tested this for thousands of beneficiaries. And the results aren't public yet and the Person- and Family-Centered Committee I think is the one that is going to be considering it but not even to mention that this is, you know a lot of the advocate family and consumer movement, this is the most exciting CMS measure area currently

happening.

And so just an example of we nod but then we don't -- we move on to something else. So, starting with the beneficiary and their experience and expectations is what many of us are all about.

CO-CHAIR HANRAHAN: I thank you for that, Clarke. The core concept, though, that you are speaking to, what would you say it is? Because I think all of those kind of segments that you just gave us, the shared decisionmaking, sense of control autonomy, community integration and participation, from an individual perspective, those are the core. But how does that then raise up to a core that would be something we could apply across populations?

MEMBER ROSS: So, the National Core Indicators is an effort to aggregate the personal interviews that are conducted with beneficiaries. There is also a family interview process and we can debate whether the number interviewer or representative of the population and that is

another methodological question but it is how you structure -- if you adapt a CAHPS Survey appropriate to the needs of beneficiaries who live in the community and face these challenges, and we have those instruments that are being used in one little form or another, we can aggregate what people are telling us, other data folks can tell us what a meaningful aggregation of data is, based on how we ask questions and how people respond.

So, and I don't think this is an impossible gap. It is a gap but we can close this gap if we are serious about doing it.

CO-CHAIR HANSEN: I have next Christine and then Gregg, Michael, and Tom.

MEMBER AGUIAR: So, I was just going to say that I do agree with this idea of the common core, a core set of measures. I think especially if applied not just by provider type but across a population really is driving towards the delivery system we have formed that really is needed.

One barrier to data particularly that I wanted to raise, this is something that our plans experience a lot is we call it 42 CFR Part 2 and it is that even within a care team, the behavioral health providers cannot share information about substance abuse treatment with the rest of the care team without consent. And so there are some ways that either they are obviously trying to get their consent but that is a barrier that we have seen both in our Medicaid plans and in our D-SNPs and also in our duals demos plans, which have the behavioral health integrated with the long-term care.

So, that is something that we are advocating for not for that privacy to not exist but for exemptions for care coordination. But I just wanted to raise that as an actual barrier towards collection and sharing of data information.

And then the final thing that I just wanted to add is I have talked with the plans about providing person-centered measures, shared

decisionmaking, self-direction and that is a direction I think that they are supportive of. What I think I have heard from them that sometimes there is a tension between what the individual wants and what you would think is best for them in terms of quality of care. So you know selecting your own care giver and then it turns out they are monitoring their care giver. They are not actually there and sometimes it is a relative.

So, you can get into sticky granular, very person-specific situations. And I don't know how you develop a measure that would allow for those situations but it is just something to be aware of when moving towards what I think are very important measures to capture the patient experience.

CO-CHAIR HANSEN: I think you have pointed out where there is this area of conflict that many people have identified in terms of the privacy here. And somewhere we need to bookmark this and come back to it.

Okay, I have then next Gregg, Michael and whose tent card? Sorry, I can't see it.

MEMBER WARSHAW: I appreciate the discussion about trying to develop some common measures. As a clinician working with a lot of people with multiple chronic illnesses, a variety of process measures only get me so far. They are not always as helpful as they could be, particularly in the individual cases.

I am really interested in making sure that we are assessing goals of care for individuals that they actually communicate what they want out of their interaction with me so I know what their future expectations are.

Like you said, not everybody agrees with me. And so it is a negotiable thing. I have a lot of older patients who are not that interested in having their blood pressure totally controlled. And I know the value of that and I usually have to use some hard sell to get that done but I have to work on that and make sure they understand. Otherwise, they are not going

to partner with me.

I am also really glad to see that we have on the agenda many functional outcome measures which to me, as a geriatrician, are really important.

I'm not sure that we can really get to measuring value in the system and value for individuals until we are measuring function in a common way across settings, so that we actually know that what we are accomplishing is actually leaving the person more independent, more able to live in the community. A lot of times I feel like some of our treatment has too many adverse effects and we end up with a person who really is more dependent after the treatment than before and I'm not sure that is the outcome that they would have hoped for.

So, I'm really glad to see those functional measures. I think those will be part of the core.

CO-CHAIR HANSEN: Michael.

MEMBER MONSON: Yes, I agree with the

concept. The one thing that I would just point out is that in terms of a barrier, one of the barriers -- because Clarke is right, there is a cost involved with all of this, but I think what we are not doing is not leveraging the apparatus that we have already built, whether in the fee for service system or in the MLTSS system.

We have people visiting people in their homes on a very regular basis and collecting lots of information and we don't use it. Now, it is unaudited. So, you would need to put in some kind of auditing system to make sure that it is valid. And there are states that are doing this like New York. But this would be a way to capture a huge chunk of this data that we are talking about because that is one of the big barriers is we are missing these data points, these key data points, the functional data points. How do you know what someone's functional score is if you are not observing them in the home? How do you understand someone's quality of life without asking them questions

like the NCAID questions?

I mean we could create a system that would, it doesn't have to be a universal assessment but potentially some common questions, a common core that would go across, which would include elements at NCAID, key functional measures, key clinical quality measures, key satisfaction measures. Have it then validated in a mechanism, in an auditing type of mechanism and then suddenly, we have got a lot of rich data that we can use and we can monitor and we will really understand what is happening with people.

So, I think we shouldn't forget that we actually have an apparatus in place. We are just not using it.

CO-CHAIR HANSEN: Thank you.

Tom and then Aline.

MEMBER LUTZOW: Yes, I don't disagree with anything that has been said. We already have one measure that is part of the common core. It is readmission prevention.

I think the common core would need to

be looked at differently. Its job is maybe not to create differentiation. Its job would be to create efficiencies through collaboration. The goal would be to raise all ships.

And I would like to fund all expectations. And the only way to do that, given the budget neutrality principles is it generates savings so resources could be reallocated elsewhere.

And it seems to me the only way to do that, to get those efficiencies, is to get all horses in the team pulling the wagon in the same direction.

So, that is the job of the common core, to get the team pulling in the same direction. And if we do that, we are going to have money to fund telehealth and telemonitoring and other things that we feel may be unfunded expectations.

CO-CHAIR HANSEN: Thank you. Aline.

MEMBER HOLMES: So, I work in New Jersey, one of the most diverse states in the

country and I am also one of the 17 hospital engagement network directors for our state.

So, one of the things that we have been talking with CMMI is the importance of breaking down the data and especially around readmission data by race and ethnicity as well as age group. But race and ethnicity for our state is really critical because we have over 100 languages spoken as primary languages in our homes and we have large populations of individuals born outside the country and expanding families. And so we have really had to start drilling down.

So, I think I agree with the common core but I think we have to overlay something around race and ethnicity because there are parts in this country, and it is going to continue to happen, that we are going to see increasing diversity. And what works for readmissions and the white population has no bearing on trying to work with East Asians and other populations and various populations from Central and South

America. So, we have to drill down and then exercise or develop interventions for each one of those populations.

CO-CHAIR HANSEN: Thank you. Well, that actually ties a bit to one of the segments that we are going to have.

And then Alice, you will have the last comment before we move on.

MEMBER LIND: So, if I promise not to talk about the slides again tomorrow, could I use two of my slide from my tomorrow slide deck to talk about how we addressed core measures in Washington? Do you have them up that you could slide to them really fast? At least in the previous version, they were 252-ish.

I just think it is kind of helpful because it seems like -- okay, so start with that 252.

We had two different legislative mandates in Washington, about the same, actually, coming out of the session 2013 to 2014 and because of the legislature having its own

interests in developing common measures, two different processes were used to come up with a common set. This one that is on the slide right now is a common set of measures that was across the whole population. So, it was commercial, Medicaid, Medicare, whatever. You know it was just like if you want to look at the health of the State of Washington, here is all the measures that we think are important. It was a long, laborious process of many, many stakeholders, you can imagine, three different workgroups population measures, cost, and the clinical measures break up into prevention and acute kind of thing.

So, you could see they are like heavily medical, heavy, heavy medical. A lot of what the kind of same measures that we have in the duals process.

So then if you back one slide, the other process that was a used for the Medicaid population, coming out of a whole different piece of legislation was if you are going to contract

out care for the Medicaid population, be it aging, behavioral health or medical, we want you to focus on more important kind of end goals, health and wellness, housing, education, criminal justice, and quality of life. And so that, again, with some overlap of stakeholders but still with that same goal of what are the important things across the whole population but now just focusing on Medicaid came up with such different measures. Some of these are kind of home-grown. We don't have standard measures for all of these things but I think it gets to that point of the question being if we don't have good coordination, what is going to be impacted.

So, you are going to end up with people not being housed. You are going to end up with people having more days in jail. You are going to have people who don't cycle back into the work world after they have resolved their acute condition. And I think that that process really got us to a better place, if you think about the needs of dual eligibles, it is really

more about wellness, quality of life and kind of ultimate outcomes.

So, now I won't talk about it tomorrow. So, steal five minutes from myself.

CO-CHAIR HANRAHAN: So, Alice, to me what you just said really represents, for lack of a better word, local work that has been done on these core issues and it is not just happening in Washington. It has been happening everywhere for about ten years.

And so you know I think that there has been acknowledged that we have been doing, and successfully doing, a lot of work. How can we -- I think it might have been Gregg or George that said this. How can we reward these kinds of initiatives and then elevate the concept of the core concept to a population level that then gets incentivized by our federal government with money because the best incentive is money, ultimately?

And we are taking these measures or thinking about these measures and elevating the core and then letting our federal government

really manage at that population level. Where I see the federal government going, this is my personal opinion, is they start telling doctors what to do and how to do it, or they tell women what to do with their bodies, or whatever.

Where I want to see them really working is using the resources that -- societal resources to drive more efficiencies in the healthcare situation.

So, I see a few cards going up.

MS. ANDERSON: So we, as staff, do our best to estimate our times. And I want to recognize that we are now 45 minutes behind our agenda.

And thank you all so very, very much for your insightful comments. We do have another day and a half to continue to share our thoughts. And so if you have a burning 30 seconds, you are welcome to share it, Kim. Okay, you will get it in later? You want the 30 seconds?

MEMBER RASK: Yes. I think related -- one point I was thinking about a common core is

that there are times where if it can be -- there are some outcome measures that are general enough that can fit in a common core, even though they are measuring what may be very different interventions and very different processes that feed into them.

And one quick example is we looked at medication adherence across a variety of chronic medical conditions and psychiatric conditions in our Medicaid patients and found a really nice gradient of the lowest medication adherence for our fee for service members and moving up through the various levels of care management and case management.

And this was case management with non-clinical case managers but we were able to show to the state that you know what, case management, even if it is not medically focused but just facilitating getting prescriptions regularly, getting them refilled, we can ensure that members are receiving more than 80 percent of the doses of the recommended medication.

So, something like medication adherence can be a common sort of outcome measure. I mean the data is not full but what it is measuring is a lot of this other care coordination behind it. It is not the specifics but you could roll it up over different groups. And we have been able to use that to kind of say here are some high performance or even looking at different case management groups in the same waiver program. How come your members seem to do so much better than someone else's members on medication adherence? Are there some lessons learned or are there some things that you are doing that someone else isn't?

MS. ANDERSON: That will be really helpful when we talk about a medication management measure that is no longer endorsed and talk about what we want to do in the family.

So, we are going to roll right through into the next section. And I am going to invite Erin O'Rourke, as a staff member, to join me in the presentation.

We are going to be on slide 43, for those on the phone and in the room who have slides, and also for Janine who is so patient with us.

And I am going to ask you be very patient with me and to hold your comments and questions. I'm excited, too, that Erin is going to be here because we have another topic that is really going to continue to fuel the fire that is lit underneath you in this discussion about risk adjustment for sociodemographic status. So, she is going to follow some background that you may be familiar with but make sure everyone is on the same setting to talk a little bit about our family of measures and the process that we are going to undertake this afternoon to update that family.

And so we want to make sure that the workgroup is really full prepared to make decisions and recommendation to CMS this afternoon about the family of measures for dual eligible beneficiaries.

We are going to start with a brief overview about the measure selection criteria, a discussion of the National Quality Strategy priorities. We are also going to go over the current features, the family that the workgroup has previously voted on and the starter set and the gap areas that the workgroup has prioritized.

So, the MAP measure selection criteria -- so, MAP has developed the family of measures for dual beneficiaries as the best available measures. They are intended as a resource for those who are selecting measures within high-need subgroups and within the population of dual beneficiaries, generally.

So, it is an intended resource and includes a Starter Set of essential measures for the population.

The workgroup continues to periodically update the family of measures, by considering changes to selected measures and newly endorsed measures for their ability to address high leverage opportunities.

So, the MAP measure selection criteria is one of the foundations from which the MAP family of measures has been built. It includes seven different criteria and I am going to highlight some of them for you.

While the dual beneficiary population does not have a specific program for reporting, we heard from our CMS colleagues how they try and work across programs and make sure that this workgroup's input is importantly represented.

We also want to remind you and thank our liaisons this year and in the past that have represented this workgroup at the other MAP workgroups to provide input on the use of measures in federal programs.

I want to pay specific attention to the relevance of criteria and number five, to emphasize the importance of person- and family-centered care. We are going to hear a presentation about ongoing NQF endorsement work on this topic later today. And we are going to look at the measures that have been newly

endorsed under that project.

We also want to emphasize the importance of this criterion six, to address disparities and cultural competency in the population and in healthcare.

And shortly, Erin is going to tell you about some of the work NQF is doing to further understand the impact of risk adjustment for SDS status and factors to inform your decisionmaking.

Slide 46 lists the National Quality Strategy priorities, as they are stated by AHRQ.

We wanted to touch on these as an important contextual framework within the measure selection criteria. We were able to hear from our workgroup members that measure taking for the National Quality Strategy was not necessarily particularly helpful to organize the measures in the family but we also recognize it is a commonly used national framework for healthcare policy and measurement programs.

We also want to recognize that in the National Quality Strategy Priorities, many

measures could be tagged to one specific priority or, alternatively, many measures could be tagged to several if not all of these priorities.

So, we will discuss this more while we review the prioritization exercise results.

In 2012, the workgroup established these five high-leverage opportunities for measurement and priorities and the include quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures.

On slide 47, we want to give a graphical depiction of the overview of the family of measures. And it is important to recognize that the measures have been refined over time but they really are focused on effective communication, care coordination, health and well-being, and patient safety.

There is a balance of measures and we recognized earlier the measure application partnership has seen more outcome measures come through on the measures on the consideration list

over the past several years but we still have a balance of process measures that really reflects what is available from which to select.

As a note, we have a Starter Set of measures. These 11 measures have been voted by the workgroup as the best available and the best in ready-to-use measures. The Starter Set is intended for those who are really starting a program or really getting the initiative to get quality measures into their setting of care. Where do I start? What do I look at? And Venesa was very representative of the overwhelmingness of the 54 measures and now 79 measures in the family. So, 11 is a lot more easy to start with. So, look here first.

So, the family is not only made up of the measures that are available but it is also made up of the gap areas. And we have seven gap areas that are really important. They are goal-directed, person-center care planning and implementation; shared decisionmaking; systems to coordinate acute and long-term services and

supports with the non-medical community; beneficiary sense of control, autonomy, and self-determination; psychosocial needs; community integration, inclusion, and participation; and optimal functioning. We are going to talk more about those separately and throughout our discussion.

You may remember that we vote here at NQF and we wanted to remind you that there will be a voting to maintain the family of measures. There will be voting to add or remove a measure from the family. Sixty percent is the threshold for workgroup consensus. So, there may be a yes or a no but either has to achieve 60 percent.

And Janine was so kind as to remind how to do that and help us use the clickers. If you have any questions about that as we go, please don't hesitate.

So, we have also looked at, as a staff preliminary analysis considered the measure selection criteria, the priorities for measurement, high-leverage opportunities, and gap

areas. And we have provided that input on your slides as you can consider the measures that have been newly endorsed or the measures that are no longer endorsed.

And these staff preliminary analyses are places for us to start the conversation and we will be able to vote on staff picks, if you choose, but they are definitely not a predetermined decision.

So we had a workgroup prioritization exercise. Thank you to the eight of you who responded. It is not a great response rate. But six measures were identified as low priority and we are going to consider those for removal. Two have had endorsement removed.

There was also measures that were identified as high priority and those are measures that have had six or seven votes for high priority and those will be considered for inclusion in the Starter Set on Day 2.

In the middle, we have measures that were not identified as low priority and measures

that were identified as low priority by only one person.

So, these measures, we, as staff, have kind of determined that there is really no change. We are didn't see those as a cause for removal and we also didn't see that as enough threshold to move to the Starter Set.

Some themes from the prioritization exercise. There is a focus and a concentration on available measures that doesn't necessarily mismatch the population needs, including acute care measures, though we have heard from you all today already how much the beneficiaries really rely on post-acute and long-term care settings.

The impact of behavioral health and mental health issues is significant, while there is so much focus on the medical physical model of available measures.

And we wanted to recognize that screening assessment measures need to include elements of treatment and follow-up.

There so there are also recognized few

available measures that represent PFCC and the member's perspective, measures that very few or very limited measures that would be meaningful to individuals.

We want to also recognize the theme that there were a lot of support for measures that promote effective communication, care coordination. We have talked about that a little bit already today.

And we want to recognize that the NQS priorities created some confusion but we hope that our structure of the meeting today does not compound that and alleviates that.

And while we do have a lot of measures that have been voted into the family, we want to also recognize that there is a real need to be parsimonious or really have focus and limit the number of measures that are included in the family.

So, throughout Day 2, we are going to ask you to consider measures that should be removed from the family. We are going to ask you

to consider measures that have been newly endorsed for addition to the family. And we are going to be prioritizing measures into the Starter Set on the beginning of Day 2 and a reminder that greater than 60 percent is agreement on consensus.

I am going to pause for a drink of water and also introduce my colleague, Erin O'Rourke, who I have had the pleasure of working with for four years and who I know is going to provide you some really, really interesting information on risk adjustment.

MS. O'ROURKE: Thanks, Megan. And thanks to all of you for having me here today. I will try to be brief because I know I am the one standing between you and a delayed lunch.

I did want to give you just a quick overview of NQF's trial period for SDS adjustment. Just to cover a little bit of background, some of the varying views on why or why not to do these adjustments, just to explain the policy change to all of you, share a little

bit about the trial period, what we are doing, how it is impacting the measure evaluation process, and then share a little bit about the potential implications for your Family of Measures. Next slide.

So, just to give some quick background and make sure we are all on the same page, I did want to define risk adjustment and explain a little bit about why performance measures are risk-adjusted.

So, risk adjustment is a statistical approach that allows patient-related factors such as comorbidity and illness severity to be taken into account when calculating performance measure scores. This improves the ability of a measure to make fair and correct conclusions about quality.

As you know, NQF endorses performance measures that are intended for use in accountability applications, such as public reporting and pay for performance. So, in this context, the measure score is being used to make

a conclusion about a provider's quality in relation to either other providers or some comparator such as a national average performance because healthcare outcomes are a function of both patient attributes, as well as the care received. And patients are not randomly assigned to provides for healthcare services so that all providers would have the same mix of patients. Risk adjustment is essential to examine outcome performance in the real world.

Essentially, the purpose of risk adjustment is to provide like-to-like comparisons and without appropriate risk adjustment, providers can be misclassified based on incorrect conclusions about their performance. So, really the general question we are trying to address is how would the performance of various providers compare if, hypothetically, they had the same mix of patients? That is, if the measure scores are being used to identify which providers have better quality in order to inform the decision of a consumer about where to seek care, a purchaser

about whether or not to pay for care, or give a bonus or a penalty, a payer, how they would be setting up their network and awarding contracts, these comparisons should really be affected as little as possible by factors other than the quality of care. And that can include patient characteristics already present at the start of care. Next slide.

So, I know sociodemographic status is not a term that everyone uses. So, just to quickly define that, when we say sociodemographic status, we are referring to a variety of socioeconomic, such as income, education, and occupation, and demographic factors, such as age, primary language, household income and zip code. There is a growing body of evidence demonstrating the association between patient SDS and healthcare outcomes. And additionally, we have seen a dramatic policy shift in recent years to value base purchasing with really an increased focus on outcome measures in those pay for performance programs.

However, in general, caring for a sociodemographically disadvantaged populations is associated with poor performance on the current performance measures. And that is just on average there are some noteworthy exceptions to that general pattern. And given the higher financial stakes, especially for safety net providers, we want to ensure that the measures are really giving that apples to apples comparison between providers.

We want to ensure that the safety net providers aren't being unfairly penalized because of the population that they serve. Doing so could create greater disparities or take away the additional resources that are needed to serve vulnerable populations and close those gaps in care.

So, historically, SDS adjustment of quality measures has been avoided. We know there are at least two divergent views on adjusting measures for SDS status. Interestingly, both of these positions are really anchored and a shared

concern about worsening disparities in the healthcare system.

Those who oppose adjusting the measures for SES feel that doing so will mask disparities. They feel providers may deliver worse quality care to disadvantaged patients, adjustments could mask meaningful differences in quality. It sets a stage that perhaps worse outcomes could be expected. There might be no expectation to improve. It implies or sets a different standard for those serving vulnerable population.

I know that I don't really need to tell this to this group, as I just heard your previous conversation but there is a lack of adequate data to do these adjustments and others prefer a payment approach to help the safety net rather than adjusting the measures.

Those who support SDS adjustment feel that it is really necessary for comparative performance. And a performance score alone, whether or not it is adjusted for SDS factors

cannot identify disparities. They feel hospitals caring for the disadvantaged are already being penalized. And there is no evidence that disparities would be reduced through further negative financial incentives.

And finally, that a lack of adjustment would create a disincentive to care for the poor.

Next slide.

So, to consider an adjust these issues, NQF convened an expert panel to determine when and how quality measures should be adjusted for SDS factors. This went through the typical NQF process. We convened an expert panel composed of multiple stakeholders with a variety of experiences. And the recommendations were submitted for public comment and then modified in response to the comments received. Next slide.

The expert panel developed a set of core principles to really ground their recommendations. They noted that outcome performance measurement is critical to the aims of the NQS. They felt disparities in health and

healthcare should be identified and reduced.

Performance measurement should not lead to increased disparities. They noted outcomes may be influenced by patient health status, clinical and sociodemographic factors, in addition to the quality and effectiveness of healthcare services, treatments, and interventions. Next slide.

When used in accountability applications, measures that are influenced by factors other than the care received, particularly outcome measures, need to be adjusted for relevant differences in the case mix to avoid incorrect inferences about performance.

They noted risk adjustment may be constrained by data limitations and data collection burden. And the methods factors and rationale for risk adjustment should be transparent. Next slide.

So, based upon the recommendations of this expert panel, NQF ultimately decided to undergo a two-year trial period where performance

measures could be adjusted for SDS factors. This is prior to a permanent change in NQF policy. Previously, there had been a prohibition on the consideration of sociodemographic factors in risk adjustment. NQF preferred to see stratification based on these variables.

So, during the trial period, if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute the SDS adjusted version, the non-SDS version, that is, one that is only clinically adjusted to allow for stratification. Next slide.

The trial period really stresses that each measure must be assessed individually to determine if an SDS adjustment is appropriate. And not all outcome measures should be adjusted for these factors. In particular, an example such as CLABSI should not be adjusted, something where the stat and the end of the process is really under the control of the provider would not be appropriate.

There needs to be both a conceptual basis, that is a logical rationale or a theory, as well as empirical evidence to support the adjustment.

And finally, these recommendations may apply to any level of analysis, such as health plan, facility, and individual clinicians. Next slide.

So, all measures submitted to NQF for endorsement after April 15th of last year are considered to be part of the trial period and the standing committees evaluating them, they consider if the measure is appropriately adjusted for SDS factors. So, this includes newly submitted measures, measures undergoing endorsement maintenance, measures that were conditionally endorsed, such as the ones in the Admissions/Readmissions Project and the Cost and Resource Use Projects, as well as measures undergoing an ad hoc review. Next slide.

So, this slide just shows some of the questions that the standing committees are asked

to review when they are considering an SDS-adjusted measure. They are asked to look if there is a conceptual basis between the SDS factor and the measure focus; if the factor was present at the start of care; if there is variation in the prevalence of the factor across measured entities; if the empirical analysis that the measure developer provides shows that the factor has a significant and unique effect on the outcome and if the information on that SDS factor is available and generally accessible. Next slide.

So, this does have some implications for the Dual Eligible Beneficiaries Family of Measures. So, we wanted to make sure you were aware of the trial period and the potential impact. Five measures in the family are currently part of the trial. There are five measures from the recent Readmissions Project. That project began and ended just prior to the start of this trial period and throughout that project, we heard there were concerns about the

need for potential risk adjustment for SDS factors on these measures. Because of that, these measures were endorsed with the condition that they enter the trial and that the Standing Committee determine if there is a need to adjust these measures for SDS factors.

So, just to give you a quick update on that work, the Admissions/Readmissions Standing Committee is currently in the process of a series of meetings to review the 16 measures that were endorsed with this condition.

Some findings from the Standing Committee's preliminary review are on this slide.

The Standing Committee had concerns that the variables currently proposed by the developers may not be sufficiently robust, however, there is also a need to consider current limits to the availability and accessibility of data around these factors.

The Standing Committee noted that any patient characteristic that is present prior to treatment or is a known or suspected confounder

of the treatment may be included in the risk-adjustment model.

The committee encouraged consideration of age, gender, and some measure of poverty, as well as to test community-level variables when patient-level data were not available for sufficiently robust.

The committee noted that geographic proxy data should match the actual SDS characteristics of the patient as accurately as possible. So, I would strongly encourage use of a 9-digit ZIP code as a 5-digit might too broad brush.

And finally, the committee strongly urged caution on the use of race as a proxy for patient SDS, as it is really difficult to assess the underlying concept that that is measuring. Next slide.

So, to date, we have learned quite a bit about the challenges of risk adjusting quality measures for SDS factors. As you all were just discussing, there is really limited

available data of patient-level data, in particular the 9-digit ZIP Code/census block data that can really show the granular differences that we need. It is not easily accessible.

Risk models using currently available adjustors are not really demonstrating an association for measures with a clear conceptual basis for SDS adjustment.

We have heard some concerns about the factors selected and being analyzed to date. Available proxies may not be adequate. There has been concern about the use of race as a potential factor, as well as a call for a more prescriptive approach. Historically, NQF has not been prescriptive in its approach to the variables included in risk-adjustment models or the method used for risk adjustment. That is for the developers to determine and the Standing Committees, too, then evaluate what the developers put forth and that applies to both clinical and SDS factors. However, questions have arose about whether NQF should establish

guidelines for what factors should be considered to ensure a more consistent and thorough trial period.

So, with that, I will turn it back over to Jennie for discussion. I am happy to take any questions.

CO-CHAIR HANSEN: Any immediate responses, like comments like Thomas, your card's up?

MEMBER LUTZOW: Yes. I noticed that the measure, the measures list had a lot of adjusted, and the answer was no or yes. So in voting on the measure are we voting that it be accepted as an unadjusted measure when, in fact, CMS itself did the RAND study, has determined that that measures is affected by SES. Are we overriding anybody in voting for a measure as it's presented when we know, in fact, that it is affected by SES?

MS. ANDERSON: We are considering measures as they are currently endorsed. The measures that we have for you today and the

measures that are currently in the family are endorsed, some with risk adjustment, for clinical factors generally or other severity factors.

The trial period is new and informative, but we don't have any measures that are truly affected by -- with a decision to endorse the measure with risk adjustment for SDS factors at this time. We have in the past, and the workgroup could recommend, and participate in an infinity loop as Debjani earlier described, that we provide input to the CDP process about measures that have been endorsed or are going through the trial period, we can provide input and feedback as the question asked about recommendations to the steering committee.

MEMBER LUTZOW: So --

MS. ANDERSON: In addition --

MEMBER LUTZOW: -- no one's going to misunderstand our vote if we approve a measure that we feel should be SES adjusted. It isn't yet. CMS isn't going to misunderstand our vote that we're endorsing it as an unadjusted measure?

MS. ANDERSON: We can precisely include that information when a measure is voted for inclusion in the family, and strong encouragement for risk adjustment for SDS factors.

MEMBER LUTZOW: The other question is it seems that the sponsors are not consistent in their assessment of SES impact at the very beginning of the development of the measure. Isn't there a need before the sponsor presents a measure for them to provide information on is this impacted by SDS or not? And use a common -- and, again, you have pointed out there is no common methodology -- isn't that a fundamental weakness here?

MS. O'ROURKE: Sure. So we do ask the developers to submit that information on the measure submission form that they fill out when they put a measure forward for NQF evaluation for potential inclusion -- or potential endorsement. So we are collecting that information about the conceptual basis. They're asked to either say if

there is or is not, and justify basically why or why not SDS adjustment.

The lack of a standard methodology, we have heard that as a concern. That's historically how NQF has treated risk adjustment for clinical factors, so we are keeping that policy consistent. But we know that that has been raised as a potential limit to the trial.

CO-CHAIR HANSEN: Just a clarifying question.

Given what we know, the unevenness right now and the fact that the trial goes on, how will the findings actually be interpreted and received?

MS. O'ROURKE: Sure. So the trial is really at its essence about testing this policy about lifting a prohibition. So it would really be in a year taking a look at whether we would want to put that prohibition back in place and no longer allowing SDS factors to be considered in risk adjustment models, or continuing with this policy of allowing them to be on the table and

the developers to make that decision about whether or not they would put forward their model with those factors in.

So we know there's challenges about getting to some of the bigger picture questions about the impact of using adjusted or non-adjusted measures. We don't expect we'd be able to answer those in the two years that we have. So we're really trying to test this policy and see if it's something that we would want to make a permanent change.

CO-CHAIR HANSEN: And just to answer Tom's comment then, perhaps after two years it's really clear that some framework needed to be developed. And that might be one possible outcome to, you know, continue this process.

And two more cards, Christine and then Mady.

MEMBER AGUIAR: So my question is, if the committee in doing its research finds that perhaps the best, most reliable data to do the risk adjustment is something, so income for

example, something that perhaps is collected by census but not collected by CMS currently, could the committee recommend to CMS that this particular data needs to be collected? Or is the committee confined to working with the data that Medicare currently collects?

MS. O'ROURKE: So that has been one of the big challenges in the measures that we've currently seen come in on the endorsement side. A lot of the developers are -- do feel they're constrained to what's currently available in the claims data. So it's an evolving process of encouraging developers to look at different data sources, perhaps additional data to be collected.

There's not really an easy answer there. But the committees do have a chance to provide some more qualitative input, if you will, and make those types of recommendations that developers look beyond what's currently in the claims data.

MEMBER CHALK: So is this committee, our committee going to have access to the

information on the committee that I was involved with yesterday on the development of measures, which is the IAP various committees? Because yesterday we were talking quite specifically to people who are going to be the developers about having to include poverty as a factor in looking at all-cause readmissions.

Now, so here we go with one group of people talking to developers about including poverty. And here we're studying it as a risk adjustment factor. I just want to know that the right hand of CMS is talking to the left hand of CMS since --

MS. DAY: So are you asking about the TEP?

MEMBER CHALK: Yes.

MS. DAY: Yes. So we're all involved, so we hear the information. Yes, we are aware. The TEP process is through a contracting process, so it is separate. But that's part of why we have people like you and us sitting on -- yes. So we have to bring, we're responsible for

bringing the information.

But we do know from one to the other what's happening.

MEMBER CHALK: So that's just a piece of information now for this group, that the developers of the measures from the TEP group were asked to pay attention to poverty as an issue in readmissions.

CO-CHAIR HANRAHAN: You know, poverty has been, you know, factored in as a digesting factor for a long time. It's basically using whether or not that individual is receiving Medicaid. And that gives you the poverty guidelines, federal guidelines.

What I've heard being -- that's really interesting to me is that the recommendation is to move from a 5-number --

MEMBER CHALK: To a nine.

CO-CHAIR HANRAHAN: -- ZIP code to a 9-number ZIP code. And I don't feel like we have -- and then we're being asked to say whether or not we're recommending SDS adjustment for the

readmission committee. And I just don't have enough information because I don't know what the margin of error is between a 5-digit ZIP code and --

MEMBER CHALK: And a nine. And neither do I.

CO-CHAIR HANRAHAN: -- and a 9-digit ZIP code, you know. And maybe now 5-digit ZIP codes we know we can get that. And we know that we can't get the 9-digit ZIP code very easily.

MS. O'ROURKE: Sure.

CO-CHAIR HANRAHAN: You know, can you guide us a little more on that?

MS. O'ROURKE: Sure. So that type of decision about whether you'd adjust it to 5-digit or 9-digit level is really with the developers to make that decision about what they can do and what model they want to put forward, and then the standing committee, too, they can make an endorsement decision about whether the measure is valid.

What we're really hoping for from this

committee is some guidance as end users of these measures and experts in vulnerable populations, about are there any special considerations that you've seen around these readmissions measures that you'd want the standing committee to be aware of as they're evaluating that.

And we do know that the 9-digit ZIP code has been a challenge. It's really been something the standing committee's wanted to move forward with, as when we see the analysis on the 5-digit ZIP code, nothing is showing up. It's showing there is no difference. So I think there's been some concern that 5-digits is just not granular enough and perhaps 9-digits would show greater differences. But we know it's challenging and it's not easily available.

So that's really just an update on the status of the data.

CO-CHAIR HANSEN: But does it show results --

MS. O'ROURKE: In some preliminary studies it looks like it has, a little bit in the

literature. But I think there hasn't been a -- I mean I'm not fully, fully versed on that so I don't want to make a definitive statement -- but from what we've found, it seems a bit in the literature but not -- we haven't had a measure submitted that's been adjusted at the 9-digit level and endorsed.

CO-CHAIR HANRAHAN: I just know that, and we've talked about this a lot, about how income impacts health outcomes. So, you know, at that level I think we should be recommending that there be an SDS evaluation or adjustment. But the detail of that, you know, is really the devil's in the details and how they want to move that forward.

But you're asking us to recommend, make a recommendation to the readmissions standing committee. I mean how do others feel about this socio-economic status being part of adjustment; that being the question, right?

MS. O'ROURKE: Yeah, I think that I will able to input a little bit more on this.

You know, there's people who are strongly in favor of the adjustment, others who oppose it very strongly. So as experts around the room serving vulnerable populations, what would you say the pros and cons are?

CO-CHAIR HANSEN: We're scheduled for picking up lunch but we will actually have a working lunch as well. So we have moved toward the side of making sure people are -- comments, George.

MEMBER ANDREWS: Yeah. Out of curiosity, typically when I'm thinking of SDS, I would think that there is a whole set of variables that could play into that categorization. And so my question is has anybody, has -- I would hope that some form of covariate analysis testing has been done to assess all of those variables and determine which ones appear to have an impact on risk adjustment.

And then from that set, then ask the question, okay, does it make sense to incorporate any of these or all of these, because they are

impacting the risk adjustment independently of each other?

MS. O'ROURKE: Sure. So that's really what we're asking the developers to do in the empirical analysis. They're asked to submit for their measure endorsement. We asked them what factors they had available, what the impact of each factors was, and as well as the conceptual basis for including or not including.

MEMBER LUTZOW: Yes, in addition to SDS, disability is another factor. And I'm sure you have a copy or could get a copy of the RAND study that CMS commissioned at the end of last year that showed the disability on top of poverty as a double whammy.

I'd like to pick up on this idea that creating a framework that requires sponsors to test for SDS disability impact as part of their submission process, and a common method of measuring that. Now, I understand the data problem, but the method is not a problem. Standard statistical procedures ought to work

fine. Or, you know, logistic regression ought to work fine. It's a question of, as mentioned by Andrew, the covariates of the data sets that are used.

But, you know, can we agree at least on the set of criteria that need to be considered when even presenting a measure? It has or it does not have SDS effect; it has or has not disability effect. Those are answerable questions.

CO-CHAIR HANSEN: Okay. I think that's definitely registered. Good point.

Christine.

MEMBER AGUIAR: So to the extent that the question on the table is whether measures should be adjusted for SDS, yes, as an organization this has been one of our biggest tasks at CMS, both really with respect to the Star Rating program, the Medicare Advantage Star Rating Program, and then also in the risk adjustment system.

In the Star Rating program we've been calling for stratification. We're not -- but

we're, you know, we're open to other possibilities, whatever research shows is the best way to actually risk adjust. But that is an idea that we have been asking for CMS to test, really because it makes sense to our plans to compare like plans to like plans, which is not currently done in the Star Rating system. But that's open to other means of risk adjustment.

I would just, again, echo and add to what Tom was saying that, you know, when we talk to our plans about the issues that they have, and again this is in the context of the Star Rating system, they are working to make improvements, working with the providers to improve those quality measures.

And then what many of our members find is that there's sort of a ceiling where because of the nature of who these individuals are and all of their challenges, that is what is getting in the way of them, you know, getting the care and so it's getting in the way of the performance on the Star Rating system.

Which are the exact, you know, risk adjusters to use? I don't know. What I could just report back to you is that what we hear is there really is a difference in the full benefit individuals, the lowest income individuals. They are different than other Medicare beneficiaries. And CMS just acknowledged this and you see it's reflected in the recent change to the risk adjustment system, where CMS really did find clinical and cost distinct profiles for full benefit individuals, but also individuals with disabilities.

Other populations that we hear that have unique challenges, even within individuals with disabilities, are those with behavioral health conditions, the SPMI population and then individuals that have co-morbid depression and anxiety and other mental health conditions on top of multiple chronic conditions.

And then the other populations that we hear are very distinct is also the individuals with housing security and homeless, et cetera.

So all that is to say that I am very supportive of looking into -- of actually adjusting measures. It'd be great if the committee could also look into stratification. I think you said that it sounded like maybe you looked into that and that wasn't -- you weren't going to continue to pursue that. But I think it is incredibly important, I think both for, obviously, you think about it from a payment perspective in the Medicare Star Rating system, but also from the measuring and reporting back to stakeholders the true quality of care.

MS. O'ROURKE: Sure. And just to clarify, previously the NQF policy only supported stratification. So this new policy really brings risk adjustment into the mix as well. But we would -- if a measure does include SDS factors, we do require that there be a clinically adjusted version only made available so that people can continue to stratify.

MEMBER MONSON: Are we voting now?

MS. O'ROURKE: No. This is just a

FYI.

CO-CHAIR HANSEN: That's the intent of this presentation because many of us have been hearing about this SES work that NQF has committed to, so we've been asking for kind of a progress report along the way as we are asked to make other kinds of decisions. And I think we're bringing up other, you know, element of whether it's a 5-digit or whether it's a framework that we think is real important as we consider all of our measures.

So with that I see Clarke's about ready to -- I was going to close up the section here. Is there something, Clarke, that's part of this or can this be another discussion?

MEMBER ROSS: I wanted to ask a question about we have data on historically discriminated populations. And we have data on their disparity in utilization of certain health services.

So I'm thinking about women who use wheelchairs and they die on average earlier than

the rest of the female population in our society because of lack of access to accessible mammography. If we didn't have discriminatory practice and we had accessible practices we wouldn't have to adjust, but we don't.

And so how, how does the group build discriminatory practice that results in disparity into these adjustments?

MS. O'ROURKE: So that's an excellent question and one that I don't have an exact answer for you on. But we have convened a disparity standing committee that is taking a look at these types of issues and monitoring things like that to ensure that doing these adjustments doesn't worsen disparities because we know there are issues around discrimination and bias that we do not want to adjust away for.

So I don't have the answer for you at this time but that's something that we can definitely bring to the disparity standing committee for their consideration.

CO-CHAIR HANSEN: I think we've ended

actually with a request to include this aspect of the whole issue of discriminatory practices. So perhaps in the future we can have that be part of our meetings.

So, Megan?

MS. ANDERSON: So we have a plan at this time. So we recognize that you have been giving us your attention for more than three-and-a-half hours, and we really appreciate that. We want to in kind give you 30 minutes and ask you to come back again with your full attention. And so you get your full 30-minute lunch.

Lunch is for workgroup members and staff here in support. It is over here. I didn't have a chance to look at what it is, but I'm sure it's delicious.

And for those from the public who are in the room, we are happy to give you locations where you can grab lunch, and you are also welcome to beverages in the room.

So we will reconvene at one o'clock on the dot. And thank you all so very much.

And while you're getting back settled at about 5 minutes to, 10 minutes to, don't forget to bring up your Excel spreadsheet and get ready to talk about measures. Thanks.

(Whereupon, at 12:28 p.m., the above-entitled matter recessed, to reconvene at 1:00 p.m.)

CO-CHAIR HANSEN: We are going to get started right now. And we're moving this first part of this presentation. And this will be a lot of our lifting of working on the measures and getting to know which ones have changed in their endorsement, that some of you provided opportunity to input on what you considered lower priority.

And then there are some newer endorsed measures since our last meeting. So Megan will kick us off with this presentation.

MS. ANDERSON: Thanks so much.

We have a lot of people that are making their way back to their chairs, so I'm going to ask everyone to open up their Excel

spreadsheets that you received as part of your materials if you have a computer with you. And that will be a really helpful resource as we go through measures that are no longer endorsed.

Just to give you a base --

MEMBER MONSON: Can I just, a quick process question.

MS. ANDERSON: Yes. Could you use your microphone.

MEMBER MONSON: So is the spreadsheet the same one that we had commented on originally?

MS. ANDERSON: So the question is whether or not the spreadsheet I am discussing is the one that was the prioritization exercise you received in March. The answer to that is no. They are very similar.

This, you should have that out for reference perhaps, if you filled out that prioritization exercise, if you want to look back and reference your own responses. But what I'm asking you to do is go to either an email that you received from the MAP Dual's inbox that

Janine sent, and go to the SharePoint page or go to the calendar appointment and get the Excel sheet from there. You can also download it from the NQF website and the Dual Beneficiary Project.

So the Excel spreadsheet has four tabs. The first tab is the family of measures that includes the 76 measures that are currently endorsed in the family.

The next is the newly endorsed measures that we'll discuss.

And the last two are special alternate measures and cultural competency measures that help us understand the alternatives to measures that are no longer endorsed.

So please pull up the Excel spreadsheet that's part of your materials. And if you have any trouble getting that, please let us know on staff.

So that's an important reference document. And most of the information will also be summarized on the slides if you're not as comfortable with that. It's quite small. But we

wanted to make sure you had access to that.

So we're going to kind of describe on slide 73, I'm going to start and kind of describe the task at hand for this afternoon. It's not a small task. We have lots of measures and their applications to consider. And so we want your input. We'll be using those voting clickers that we practiced with lunch -- or for dinner earlier today.

So slide 74 describes the six measures that are no longer NQF endorsed that are currently in the family of measures. Just before lunch I described the 76 measures in the family and what those overall characteristics are. Now we're going to be looking at the measures that are no longer endorsed.

In doing this, we're going to be making changes to the family to help maintain its currency, to maintain it as a current family of measures. And the question to consider as you consider these six measures is if you would like to remove any of the measures from the family.

We're going to consider them one by one. Each of them has a slightly different scenario or consideration to think about as you make your decision.

Next slide.

We're also going to be considering newly available measures. NQF staff has done some of the work to help consider and review the 25 newly available measures since this workgroup last met and reviewed measures.

There were 15 measures that were identified to consider, 14 of which are truly applicable. But you'll see 15 today. And I will explain that when it comes to the medication measures.

The remainder of the measures were determined inappropriate for the population or really do not address the high leverage opportunity or gap area.

And so we on staff, tried to help make this a more manageable level of decision making. And so we'll be looking at 15 newly-endorsed

measures today.

So the question to consider is would the workgroup like to add any of these 15 measures that have been newly endorsed to the family?

Would you like to replace any measures that are in the family? Because what you see here -- because one of the newly endorsed measures is far better and better meets the needs of the population.

There are also -- this is a breakdown of the measures that received endorsement recently. You will notice that there weren't any affordability measures, so we don't have any to consider.

While health and well-being is a priority area for this population from this workgroup's preferences, we noted that the health and well-being measures that were newly endorsed did not address the target population or were not appropriate.

There were four condition-specific

measures, and they really do not address any of the priorities that this workgroup has previously expressed. We are not presenting them for you to consider today.

There were also two measures that were limited to children. Again, not appropriate for the populations that they're -- the population is made up largely of adults. And we have not included in the past any measures that are specific to children.

There are also three measures of prevention treatment for leading causes of mortality. Again, these are condition-specific measures that we're not putting to the workgroup today to consider; they're considered too narrow for the family.

And there are three patient safety measures. There are two measures of medication safety, and there is another condition-specific measure but it's considered too narrow for the family. It is presented along with these other two, mostly because it seems fair and seems a

little odd to rule out one and the other two will be presented.

There is one measure of effective care coordination and communication but was considered, again, too condition-specific and too narrow for the family.

The bulk of your work for measures that have received endorsement since you last met is going to be focused at the 3:00 o'clock agenda item and will take us to the end of the day. And there it's 12 person- and family-centered care measures that have been recently endorsed.

These measures have been looked at and really do address priority gap areas that the workgroup has identified and raised, especially optimal functioning, as we heard a little bit earlier today, and person- and family-centered care.

And so I'm going to pause here and see if there are any questions about what we are about to embark on.

Jim, have you been able to join us on

the phone?

MEMBER DUNFORD: Hello. Yes.

MS. ANDERSON: Thank you.

MEMBER DUNFORD: Jim Dunford here.

MS. ANDERSON: Are you also on the web platform?

MEMBER DUNFORD: I am.

MS. ANDERSON: Great. And so you'll vote in the chat box?

MEMBER DUNFORD: I will.

MS. ANDERSON: Thank you.

MEMBER DUNFORD: Thank you.

MS. ANDERSON: And I wanted to see if D.E.B. Potter has joined us on the phone.

(No response.)

MS. ANDERSON: Okay. We're expecting D.E.B. at some point on the phone. But as a federal liaison she won't be voting.

So everyone will be voting as we consider these measures for removal or addition to the family. Have your clicker in your right hand or your left hand, however you like it, and

we'll get started by considering the first measures that are no longer endorsed.

Okay, so next slide. Next.

Okay. So the workgroup in 2015 reviewed measure 0007, NCQA Supplemental CAHPS Measure. It's an adult questionnaire. This measure was retired by the steward because they are undertaking substantial revisions onto this shared decision-making care coordination questions, which are a priority that this workgroup has previously expressed.

The workgroup previously voted to retain this measure in the family. And that is because of the fact that it's going to be updated. A new version will be submitted but it is likely still in use while the measure is being updated. It is like other measures where we've voted to retain it in the family.

The workgroup, however, identified it as low priority for a vote because it's no longer endorsed. So we felt it was warranted to bring it back to the workgroup just to keep you

informed of what the workgroup decision was in 2015 and to make sure that that workgroup decision stands, and whether or not there's any discussion that the workgroup wants to have about overturning the 2015 decision, and whether or not you want to continue to retain it or remove it from the family.

We do not have a specific timeline in which the new measure would be submitted to NQF for endorsement, but we understand that it's a matter of years, not decades.

Clarke?

MEMBER ROSS: Just an observation. I believe there are 21 members of the workgroup eligible to vote in the priority process. You received 8 out of 21 and on this you actually received 6 out of 21. So the exercise we went through is not even representative of our group sitting here today.

So I'd just make that observation when we consider what the workgroup prioritization exercise results were.

MS. ANDERSON: Very much appreciate the comment. We do thank the workgroup members that did provide their prioritization exercise results. And we understand that many of you have very busy schedules. And so this piece of information is, again, provided to inform but not make the decision. The decision has not yet been made for anything that has a workgroup prioritization exercise result.

And so, yeah, that's all. Is that okay?

As a note, we have 21 workgroup members that are eligible to vote. We have 17 that are present for voting. We are missing three that would be eligible to vote. And so our -- we did get quorum, however, consensus is 11. So 11 individuals must vote in one direction or another to have consensus as we vote.

So is there any interest in discussing removing this measure from the family or is everyone in agreement that we retain the decision from 2015 to retain the measure? Any discussion?

MEMBER RASK: This is a question. So this isn't discussion -- is this discussion about the decision or is it discussion about whether or not to hold a vote?

MS. ANDERSON: We can hold a vote. Probably it's just clean and cut if we do. But is there any discussion about overturning the 2015 decision and removing this measure from the family because it's no longer endorsed?

MEMBER RASK: Okay. And I would, I think that we should consider removing it because it's no longer endorsed and there isn't a short time period to expect a replacement. And that's been since 2015. So I think we should consider it.

MS. ANDERSON: Other thoughts?

MEMBER ROSS: So every measure we consider has methodological weaknesses and has problems. Like this one says sensitivity to cultural differences. So I tend to vote for flawed measures that measure things that are highly important to me and the Consortium for

Citizens with Disabilities.

So measures that, and given the lack of consumer perspective and consumer experience measures, I tend to continue to support them even though they're flawed measures. And until we reach some threshold of meaningful consumer experience, I will personally continue to vote for maintaining these and acknowledging their limit -- that all of our measures are limited and flawed.

So that's just a preamble of how I'm going to vote on consumer experience of respective measures. Thank you.

CO-CHAIR HANRAHAN: So just to paraphrase that, you would vote to retain the 2015 decision.

Gwen?

MEMBER BUHR: I've got a question. Are there any other measures that measure shared decision-making?

MS. ANDERSON: Answering a different question, there are other measures of shared

decision-making, yes. The advanced care plan measure that's included in the family, and we'll also talk about --

MEMBER BUHR: Because I think that might inform the decision. If we have another measure that's going to cover this one and is endorsed, then I would vote differently than if we didn't.

MS. ANDERSON: We have several other experience of care measures, including the ECHO Survey that's with behavioral health, as well as other CAHPS measures that are included in the family. The challenge of shared decision making measures has been longstanding and there are measures that touch on it. But it's hard to measure directly so we have always had that as a gap.

CO-CHAIR HANSEN: Other discussion? Shall we vote?

MS. ANDERSON: And so Option 1 will be to retain the measure in the family, so it's a keep. And Option Number 2 will be to -- so if

you want to retain the measure in the family you would vote yes. No. You would vote no. Excuse me.

I apologize. You may remember I was missing last year. I was dealing with my phone, so I apologize, it's my first time using the clickers.

So, Janine, do you want to say it?

MS. AMIRAULT: Sure.

MS. ANDERSON: Thank you.

MS. AMIRAULT: So if you're voting to remove this measure, click 1 for yes. And if you would like to retain it, 2 for no.

(Voting.)

MS. AMIRAULT: Okay, looks like consensus hasn't been reached on this one.

MS. ANDERSON: So we need at least 60 percent consensus, and so I think we need to have some further discussion.

Go ahead, Gregg.

MEMBER WARSHAW: So maybe we could just speak to the implications of a non-endorsed

measure. What does it mean to be non-endorsed? And what are the implications of it, of continuing to have a non-endorsed measure in the family?

MS. ANDERSON: Okay. So we rely on the consensus involvement process to endorse measures based on their reliability and validity and several endorsement criteria. By retaining a measure that is no longer endorsed, we are not receiving annual updates and maintenance information from the steward and the developer.

In that there may be changes to a measure that are needed that aren't being done and being maintained to specification. By having this measure we're recognizing that annual update process is not happening while a new measure is being -- while the measure is undergoing substantial revisions.

Because it's a CAHPS measure, the workgroup recognized last year that it was going to be in continued use across peer study -- excuse me, across populations, despite the fact

that it was not going to be endorsed and the steward was just not using the resources to maintain endorsement while they were using resources for development and updates.

So I think that the implications are that we are understanding that there may be tweaks that could be made to the specifications that are not being made on an annual basis, but that the measure has been used for a very long time, is generally, if not always, has been sound for a substantial period of time, and that it's still largely in use.

And we have also recognized the measure selection criteria, that the burden of measurement is high and stability of measurement across -- across measures, stability across measures that is highly valued for end users.

Any other questions? Tom?

MEMBER LUTZOW: Did the measure sponsor have an opinion on this?

MS. ANDERSON: Because we had them come last year they shared those thoughts that

I'm summarizing last year. And we haven't asked them to come to this, this meeting today. But they shared that they will be updating the measure and that it was largely still in use by other CAHPS measures. Still in use with other CAHPS measures.

However, Kimberly's point is valid that we have not yet received an update.

Are we ready to call another vote? Does anyone have any remaining questions? And, Janine, I'm going to ask you to say it correctly so I don't make it the wrong vote.

MS. AMIRAULT: Okay, so you're voting -- give me just one moment. It will be 1 to remove the measure and 2 to retain.

(Voting.)

MS. AMIRAULT: Okay, so based on the percentage, the consensus is to remove the measure.

MS. ANDERSON: All right. Thank you all. That was the easy one.

So you may have noticed everyone can

kind of take a break for a minute while I -- I'm trying to keep track of the measures that we're going to vote on because I think it's important that that's highly visible. We'll also summarize these things at the beginning of the morning.

Our Senior Vice President is going to take notes for us. Thank you, Marcia.

So, the next slide.

The next measure for us to consider is measure 0054, Medication Reconciliation Post-Discharge.

This measure is no longer being maintained as an individual measure. We noted that this measure has been combined with measure 0097, Medication Reconciliation Post-Discharge, and which is already, and has no change to endorsement, so it's currently in the family. And we would expect that would stay in the family.

This is a positive change. It's harmonization with measures that are similar. And it's really a great, great process change.

So the measure is the percentage of discharges during the 11 months of the measure year for patients 66 years old and older that were reconciled within 30 days of discharge. The workgroup did vote and 4 votes for high priority, 3 votes for low priority, because an endorsement has been removed. And there are three related measures of medication management and transitions in the family.

So the three related measures are 0419, Documentation of Current Medications in the Medical Records; 0054 -- excuse me, 0554, which is the measure under consideration; and 0646, Reconciled Measures List Received by Discharged Patients.

So the question to the workgroup is whether or not this Measure 0054, Medication Reconciliation Post-Discharge should be removed from the family because it is no longer endorsed and maintained as an individual measure, with the note that it has been combined with 0097 which is in the family, retains the qualities of this

measure.

Are there any questions or concerns?

MEMBER MONSON: So when you say it's been retained, without getting into each one, is it fully contained so the entire essence of the question is embedded in the other questions? So if we get rid of it we don't lose anything?

MS. ANDERSON: Right.

MEMBER MONSON: Thank you.

MS. ANDERSON: You lose a number.

MEMBER MONSON: Well.

MS. ANDERSON: Which is nice.

Any other questions or concerns? Seeing none, Jim, any questions? So we are going --

MEMBER DUNFORD: No. No, my same question as before. It sounds like it's included in the new measure. Thanks.

MS. AMIRAULT: Okay. So 1 for removal and 2 for retaining.

(Voting.)

MS. AMIRAULT: If everyone wouldn't

mind just pointing one more time and casting their vote. Thank you.

And just one more time. Sorry.

MS. ANDERSON: I think we may have gotten the -- so we're moving the measure. Fantastic.

Okay. Thank you all for your patience. I'm sorry we didn't see him step out.

We're going to move on to the next slide where we're going to consider measure 0692, Consumer Assessment of Health Providers and Systems, Nursing Home Survey: Long Stay Resident Instrument.

This measure was not included in the exercise materials. Important to note. So the prioritization exercise in March, this team should not occur in that, your set of materials. So it did occur and was represented in materials received last workgroup meeting.

The steward is no longer maintaining this measure and maintaining performance measures derived from survey items. It is part of the

field evolution. And as we learn and grow as a field together to understand the difference between surveys and measures.

So the instrument is not being endorsed anymore. It includes five topics on environment, care, communication and respect, autonomy and activities, and provided nursing level -- nursing home level scores on three global items.

While it was voted high priority by 6 measures, it was because the quality of care is important and varies, but it also is really important to consumers.

Now, the preliminary analysis is to remove the measure and consider addition of newly-endorsed measures that address priorities in person- and family-centered care, which we're going to review this afternoon, but which is on there as well.

And so I think it's important to recognize here that we have other CAHPS measures in the family that are measures based off of

survey items. However, this measure is not truly a measure that is NQF endorsable and so it is more really an instrument. And so it is no longer being maintained by the steward.

And I'm going -- happy to take questions. So Joan goes first.

MEMBER ZLOTNIK: So I understand that it's no longer endorsed and there is this question of whether it's a measure or not. However, considering that of the eight people who did the exercise, six of them saw this as a high priority. And it addresses critical issues related to nursing home residents.

I'm wary of removing it without actually seeing what those other measures are and whether they actually encapsulate some of the absolute missing elements of most nursing home care in the U.S., like communication, respect and autonomy. So it's a hard decision to make because I don't feel like I have enough information to actually do it.

MS. ANDERSON: Unfortunately, I think

the lack of endorsement of alternative measures that I can offer you to consider to replace this measure is reflective of our priority CAHPS list. And while the measures of person- and family-centered care are -- make progress on functional status, they do not focus on these elements as specifically as I think you are looking for.

And so I don't have alternatives to offer, although I looked.

CO-CHAIR HANRAHAN: My understanding is then, if a measure is not -- if there's not a steward, the steward isn't maintaining the measure then that measure has to go. Is that basically how it goes?

MS. ANDERSON: It's no longer going to be valid and reliable. It's really hard to make a recommendation to CMS to use it.

MEMBER STUART: But then the question becomes these are, you know, five important value areas. And if we simply drop it because there is no steward, we're dropping some of these aspects of care.

MS. ANDERSON: So I think it's important to note that the steward is recognizing the measurement science behind this and that it's an important instrument that -- while the CAHPS surveys are still in use, that this does not result in a valid, reliable, NQF endorsable measure.

And one recommendation that I haven't quite heard but I'm hearing inklings of is that there should be a valid and reliable, NQF endorsable measure based on these concepts. And so that could be a recommendation if the workgroup chose to develop that.

MEMBER ROSS: I believe a number of states are using this measure currently. It takes states a long time to adopt a measure and then it takes them some time to replace them. So I guess my thinking is this addresses some very important aspects that are valued by residents. It's a resident-value measure and states are using it, despite the status of the measure's steward.

So I'm going to continue to retain this one. If states collectively drop it because of the National Quality Forum and they can replace it with something better, that's another topic for another day.

CO-CHAIR HANRAHAN: You know, I see this process as being housekeeping process. So if NQF says that this is not a valid measure because it doesn't meet the requirements that are established around science validity, then it seems -- and so they're recommending that we not endorse this measure, despite the fact that this measure is measuring concepts that we would like to have measured, could we not endorse this measure but recommend that another measure be developed that has these concepts that make it a valid measure?

MEMBER ROSS: Then it becomes a gap area. And I think we should recognize the board and leadership of the National Quality Forum wants to reduce measures because they're being criticized by providers and plans and us and

other people that there are too many measures. And I don't want to be part of the dynamic -- the meeting was successful because we eliminated x number. I don't want the other side to say the meeting was successful because we added 25, or whatever the number is.

But there is this pressure to reduce, reduce, take away. And I'm okay if it's a replacement. But to say for a measure to be developed in the future means it's a gap, these areas that states require now will become a gap area in the way of classification at the National Quality Forum in my view, so.

MS. ANDERSON: Marcia?

DR. WILSON: I'll just make a brief comment.

The discussion we're having here plays out in almost every committee meeting that we have. And I don't have a simple answer for you. I am going to leave it to the wisdom of the committee to decide. And the conversation that we often here is much like one we're hearing now.

For example, we have a process measure that's been in use for a long time. It does not -- the steward may elect not to continue the endorsement or it may not have the endorsement maintained. And the complaint that you hear is if this measure is gone does it mean we are not going to pay attention to those important issues.

And so I don't know if that's any help at all. But this is the conundrum that you're talking about, Clarke, is one that's connected. I would not want the committee to feel pressure in terms of, oh, we must reduce some measures. That was definitely not the mandate that we are giving you. That is not the charge to the committee.

I think the consideration, as Megan has said, is that this measure will no longer stand for reasons, for certain reasons. And, yes, you're right, if endorsement is moved then it does create a gap that the committee identifies as a gap area for future development. And this is a challenging issue because now, now

we have to wait for that gap to get filled, and we want that gap to be filled.

So I'm just saying this conversation, we have heard this conversation before and we leave it to the individual committees to determine whether they keep something before them because they feel like it identifies an important area or they decide not to keep that measure and identify where they want the measure developers to go.

MEMBER DUNFORD: Hi, this is Jim. I just don't want perfect to be the enemy of good. And so that's the concept I think that Clarke is also alluding to is what I'd like to know from a practical term is when would the next best be available?

MS. ANDERSON: I don't have that kind of information. I think we heard from CMS some really promising information earlier this morning about how they have contracts for development of six new measures for low beneficiaries and 12 measures for Medicaid beneficiaries. However, we

are not privy to the titles and specifications of those measures at this time.

MEMBER MONSON: So I ask this at the humility of being a new member of the group, but is there a way for us, you know, like on the stars measures there's display measures and there's measures that count. Is there a way for us to keep this as one that would -- we are basically saying we think it's valuable. Right? We understand that there's limitations in the science but we don't want to just discard it, so we can put it off into another bucket.

Is that an option or that -- is this an either/or?

MS. ANDERSON: There is a way to reemphasize and the gap area that this instrument leaves, the void that it leaves, to provide a description of that and to encourage development of a measure. There is somewhat a yes/no answer that needs to be made of is this measure in the family or not?

However, in the case of CAHPS

measures, the workgroup has previously generally supported the use of experience of care and any question of that type of data. And so CAHPS instruments, surveys, tools, measures generally has been largely supported.

So you could express continued support for use of CAHPS generally while this instrument is continuing to be used in nursing homes. It is no longer -- it is not a valid and reliable measure, therefore it does not belong in the family as a measure. So there could be a distinction for support of CAHPS generally but remove the measure because it's not endorsable.

It is a conceptual challenge. And I didn't start with this one because it wasn't the easy one. Okay? Does that help?

CO-CHAIR HANSEN: I think this is kind of the prototype of the example of the conflicts that we're going to continue to face because of the nature of the content is stuff that is already identified in our gap area. But then there is the methodological issue going on.

So as you were saying that this is going on in other areas, and so I think, Michael, your suggestion and the ability perhaps to, for the Coordinating Committee to take this into consideration.

MS. ANDERSON: Go ahead.

MEMBER RASK: I understand the conundrum that we're in is balancing that we don't want, you know, good is not the enemy, if it's all we have. But the other thing I think is we have the one thing that NQF has a role as is we're kind of a good housekeeping seal of approval. And if we don't include the measure in the family it doesn't disappear. But if we do include it in the family then we're saying if you use this tool it's valid, reliable, and you newer doctors ought to consider adopting it.

And that's the part that concerns me because I'm happy, and I think anyone who is currently using it and wanting to continue and not wanting to change their program, probably that's what they're going to do. But what I

would hate is for someone to come and look at it and say I'm looking at a new measurement. This must be a good one, it's being listed here.

So that's where I recognize this and so I kind of lean more towards saying I don't want to give it that good housekeeping seal of approval, I do want to make it clear that, you know, note in our gaps that we need more good measures like this, and this measure is out there. But we can't really hold it up as one of the best.

MS. ANDERSON: Joan.

MEMBER ZLOTNIK: I guess the problem is the voting process. So if I could vote and say, yes, you could remove this but and have that right there, then it works for the reasons that Jim and other people have talked about. But by just voting on it without that is a very hard process.

So if we can vote kind of with an asterisk and do it that way, it becomes very different than just voting it out.

MS. ANDERSON: Okay. I'm going to ask you what that but would be but I'm also going to make sure that Tom gets to share his thoughts.

MEMBER DUNFORD: Yeah. I have never met a measure that doesn't capture a value and a good. On the other hand, if a measure does an imperfect job, an invalid job of measuring the good, then I can't support it. That doesn't mean I dismiss the good.

My concern generally with CAHPS -- and I know it's gotten criticism, it's not translated into Hmong, it's not translated into Russian, and so I think there's a Spanish translation and an English version and so on and that's the limit of it -- we have evidence with CAHPS, and to me it's not going to dismiss the value, it's very valuable, but we sent out a survey outside the CAHPS survey period that was pretty much identical to the gap survey. And got it back and were sort of surprised at the results there.

There were a number of ones that were circled by some of our members. And we went back

to the member and said, Why did you circle number one on this?

Because you're number one.

No, see we're number ten if you think we're number one.

And I do think that there's probably a lack of clarity in we don't make the right assumptions about literacy levels and that sort of thing in that survey. And someone needs to pay closer attention to that, to that instrument and what's coming back through it.

MS. ANDERSON: So I don't see any other cards up.

Joan, would you like to propose a "but," remove the measure and other, other things to vote on?

MEMBER ZLOTNIK: I guess I would say that the MAP Committee voted to remove the measure for the fact that it's no longer endorsed and there are issues with it. However, the topics valued by residents in terms of environment, care and communication, respect,

autonomy and activities, particularly related to nursing home residents, are critically important issues for dual eligible populations, particularly those in residential programs.

And I want to highlight that as a critical need for available measures, or some such thing.

MS. ANDERSON: Thank you for making my report writing easier.

MEMBER ZLOTNIK: Spent a lot of years writing reports.

MS. ANDERSON: So we are going to be voting to remove the measure but emphasizing that topics valued by residents are critically important for issues for the population and need to be reflected.

MS. AMIRAULT: Okay. So vote --

CO-CHAIR HANRAHAN: Is everybody clear about what we're voting?

MEMBER ROSS: So if we vote no, we're endorsing Joan's additional --

CO-CHAIR HANRAHAN: No, that's if we

vote yes we are saying remove the measure but. If we vote no, we're saying, no, keep the measure.

MS. AMIRAULT: Okay. So, again, voting for 0692 for removal from family of measures, one being yes removed, and two being no.

(Vote.)

MS. AMIRAULT: Okay, we're just going to vote once more for 0692 for removal for family of measures; one being yes, removed, and two being no.

(Voting continues.)

MS. AMIRAULT: Okay, so 15 for yes, remove; and zero no. So 100 percent.

MS. ANDERSON: Thank you. And sorry about that technical glitch.

We're going to move on to Measure 1902, Clinician's/Groups' Health Literacy Practices based on CAHPS Item Set for Addressing Health Literacy.

This measure, the conditions around

this measure are largely similar to the measure we just discussed and so this measure is no longer endorsed. Again, this measure was not -- the endorsement, our removal was not included in your exercise you received in March but it was included in the materials you received last week.

It's an item domain set communication with provider, disease self-management, communication about medicines, communications about test results, and communication about forms.

The steward is no longer maintaining performance measures derived from the survey items. Again, it is a survey and it is not NQF-endorsable measures.

The workgroup, again prioritization exercise results again provided some priority for the health literacy issue. And self-analysis, preliminary analysis is to remove the measure and consider addition of newly-endorsed measures for person- and family-centered care.

We can open it up for discussion.

CO-CHAIR HANRAHAN: And perhaps, Joan, if you may want to propose a similar type of vote after you're heard some discussion.

Any questions about this measure and retainment or removal of this measure from the family?

MEMBER ZLOTNIK: So I guess I have the same issue about health literacy is one aspect of patient- and family-centered care, and so we're in the same dilemma here I think that we were with the last one. So I would endorse the "but" suggestion.

MS. ANDERSON: Go ahead, Joan.

MEMBER ZLOTNIK: And I think Tom actually just spoke to it in the last piece in terms of talking about different populations for whom the measures sort of are not available or there's translators not available or is there lack of understanding, communication between providers and patients. So once again, it's a very critical issue. You know, is it always on those lists of things that are important?

So I've come up with a question, Do any of the person- and family-centered care measures like we're going to talk about later actually also address this? Because if you just say, yes, you know, Measure 2172 perfectly addresses it, then it's easier to say no. Otherwise I feel like we have to say -- I mean yes, whatever the answer is -- yes, removal, otherwise I'd be need to say "yes but."

MS. ANDERSON: I have no alternative health literacy measures to offer you for consideration.

Are we ready to go to a vote?

MS. AMIRAULT: Okay, so for Measure 1902 for removal from family measures, one being yes remove, two being no.

MS. ANDERSON: With a caveat. And the caveat is topics valued by residents and that are in this measure and are critically important issues for the population but not reflected in the current family of measures.

(Vote.)

MS. AMIRAULT: Okay. So for Measure 1902 for removal from family of measures, 15 saying yes, remove, and one saying no.

MS. ANDERSON: Thank you.

We're going to move on to Measure 1909, Medical Home System Survey.

This measure has had endorsement removed and the developer has withdrawn this measure and is presently no longer able to support it.

The measure Medical Home System Survey assesses the degree to which an individual primary care practice or provider has in place the structures and processes of an evidence-based patient-centered medical home.

The survey is composed of six composites that address particular domains: patient-centered access, team-based care, population of management, care management and support, care coordination and care transitions, performance measurement and quality improvement.

The workgroup prioritization results

were split: 3 votes for high priority to support innovative care, is some of the rationale; and also 3 votes for low priority, not endorsed. It's a complex measure to use, so there's provider burden, and also a limited focus, and reasonably could be measured in other ways whether or not there's evidence-based patient-centered medical home.

The preliminary analysis from staff is to remove the measure although there are no alternatives available, and to continue use of 0005, CAHPS Clinician-based measure, and development of a patient-reported outcome and experience of care performance measures that are priority gap areas.

Are there any questions or discussions on this measure?

CO-CHAIR HANRAHAN: Joan?

MEMBER ZLOTNIK: This is really a clarifying point. Are these some of the same measures that we selected because they filled gaps that otherwise weren't addressed, even

though they were not perfect measures? And so they end up being sort of the sketchiest measures because they're so hard to measure.

So it's I'm just a little concerned that we're kind of undoing our own work in a way.

MS. ANDERSON: We're not considering any changes to the family of 76 measures which is generally so large because there are only five priority areas. So we have 76 measures to address five priority areas. So there is definitely the workgroup has made efforts to try to get at those priority areas from different angles with measures that do address them from different settings analysis or differently.

And this is one measure that is no longer being maintained by the developer and so endorsement has been removed. And so if we -- you know, there is an alternative, the CAHPS measure that is currently endorsed.

It is an endorsable measure, it is not one of those measures that's going to be removed because it's just an instrument.

So I would say that, you know, that's what I recall and supporting what you're also recalling. And it's for the workgroup to discuss whether or not they want to remove this measure from the family.

MEMBER LAKIN: Just a quick question. A lot of these so-called measures that we've been looking at, the last three or four, really strike me as instruments with embedded perhaps composite measures. And I've always been told that NQF doesn't endorse instruments, it endorses measures. And I'm failing to see the distinction.

And if there isn't a distinction, should these composites that are making up the -- I'll call it an instrument because it's more than a measure -- should they be looked at individually or is that a can of worms you don't want to get into? But at the same time there's some awfully good instruments out there that we've been told flat out you can't, you can't bring forward because NQF doesn't look at

instruments.

DR. MUKHERJEE: So I will attempt at answering this question.

So, yes, it has been an evolving field and decision. And NQF does not endorse instruments, we endorse measures that are built on elements from the instrument.

So if somebody interpreting an instrument bought all the 40 different measures from that as single, separate endorsement measures, potentially we would go through them, through the process. But I think what we're trying to get is, is that validity and evidence and sort of the scientific validity of the measure and trying to see, you know, trying to parse it out when you were looking at a whole measure.

You know, a patient-reported outcome, How do you feel today? is different form a measure that has maybe six or seven different questions and then developing a measure from that is one level further to get at a certain

percentage of patients feel better, you know, when they're on this med. And then you ask this question or they are provided the surveys in their home settings.

So we're really trying to get at the true validity of what we're asking. And methodologically it's difficult to do when you have a measure that can have questions that get to different elements, which is why we need to look at the elements separately as a performance measure.

So an instrument is a PROM, a patient-reported outcome is a PRO, and a PRO/PM is a performance measure based on a question instrument.

And some of these are older measures. So if something like a CAHPS 0007 was voted in four years ago, the field has been evolving since then. So at this point if it came up for discussion it would be a different discussion than probably five years ago. So as the field is evolving, as we see more instruments, as the

instruments are becoming more complex and more composite-like, we're having to sort of change the methodology and how we adjudicate the scientific validity and the level of evidence for them.

And I'll see if Elisa wanted to add anything to that.

MS. MUNTHALI: So Debjani is right. And so also when we're looking at composites we're looking at how, we're assessing how the composites are structured and the rationale for pulling them together; they have a single score.

In the past, many years ago, and Debjani is right about the historical context of these measures, we did endorse instruments. But we have since changed our policy. So that's why you see some of this confusion between what used to happen in the past and what our current policy is now.

MEMBER DUNFORD: Hi, this is Jim Dunford from San Diego. I think in my own understanding of, you know, it is helpful if you

can provide that level of granularity. I mean at the end of the day my question is why did the measure steward decide to no longer endorse the measure?

And so just providing a little bit more context for me would be helpful to understand exactly why they decided this longstanding measure wasn't really fit anymore. That would help me decide how I'm going to vote on each of these things.

MS. ANDERSON: I don't have granularity unfortunately. But the measure, the steward was no longer able to support the endorsement of this measure.

And I know we also work with stewards trying to find an alternative steward that could support it and to make sure that their job is feasible. But it is still important that they submit data that supports the validity and the reliability of the measure ongoing as the populations continue to change.

CO-CHAIR HANRAHAN: Mady.

MEMBER CHALK: So going along with these questions, are there -- it would be helpful to have some background about whether there is any other -- Joan raised the question -- medical home measure that is patient-centered in the sense that this is asking whether, whether a practice or a provider has the structures. It isn't patient-centered. This is not patient-centered.

Practice or provider has structures in place to be able to support a patient-centered medical home. It's not like you could never find that out. It's not unfindable. Is there anything that exists such that we don't have to care about this anymore?

MS. ANDERSON: The only alternative I've been able to find off the queue is CAHPS 0005.

MEMBER CHALK: Which is?

MS. ANDERSON: Which I can read the measure description. It's also available on line number 3 of your Excel spreadsheet.

I can also offer that, as I said, there are many certification -- not many -- there are certification programs now for patient-centered medical homes as well, so certification programs.

CAHPS 0005, the Consumer Assessment Healthcare Provider and System Clinician Group Survey is a standardized survey instrument that asks patients to report on their experiences with primary and specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.

And so there are questions for adults and children. And all the questionnaires can be used in both primary settings and specialty care. And the adult survey is administered to patients 18 and older.

Any exclusions include patients that had another member of their household already sampled and patients who are institutionalized. And it is risk-adjusted at the level of analysis of clinician. And it's a data sources patient

survey and it's an ambulatory care setting only.

It is used in several federal programs, and including the CMMI, the shared -- Medicare Shared Savings Program for ACOs, CMF meaningful use for eligible professionals, PQRS, the Physician-Based Value Modifier. And it's a CMS core measure set for ACOs, TCMH and primary care measures.

So any other questions?

CO-CHAIR HANRAHAN: Kimberly.

MEMBER RASK: And I would say just from some use of that, with that tool there are questions about how your physician spoke with you, how the nurses treated you, were you able to get after-hours care, were you able to get care when you needed.

So I think it really does address many of the concepts that would be important to patients. And the other version is well-accepted. And as you pointed out it's being used by, you know, all of the payment programs that are focused around care coordination. So I think

it does grab at that.

CO-CHAIR HANRAHAN: Michael.

MEMBER MONSON: So I agree with things that are being said about CAHPS. The one thing which I think is important, maybe it's echoing what Tom was saying earlier, is that there is, there is some challenge at the top box methodology, especially with this population. I think the TEP work has shown that there may not be complete understanding of how you're voting and what it means. And if it's top box only -- I mean I don't know if we're getting into CAHPS here -- but I just do want to point out that there are challenges with CAHPS that we need to be aware of when we're talking about this population and thinking about how to better demonstrate the issues.

CO-CHAIR HANRAHAN: My question is so what does NQF require of the stewards in order to provide valid evidence that the instrument or the measure is working?

MS. MUNTHALI: So what we want to make

sure is that the quality, quantity and consistency of the evidence is there. So we are looking for a scientific review of the evidence in terms of studies. We want to make sure that there are at least five of them and that directionally the evidence is going in the same direction.

So it's pretty high rigor of evidence that the steward has to demonstrate in order to pass. This is a must pass criterion. So if a measure is evaluated on evidence and that's the first sub-criterion within inquiries to measure and report, if they are evaluated on that and they fail, the measure does not prevail and the measure is not endorsed.

CO-CHAIR HANRAHAN: I think what I'm hearing is that perhaps some of these populations and these configurations of where we're getting the data, we may not get that level of rigor.

MS. MUNTHALI: We have an exception, especially in fields in which there may be significant gaps. There may not be the studies

there to really base the measure on.

We do have an exception to the evidence that the committee can evoke. And so as a reminder, these are experts like yourself that sit on these different subject matter committees. And so they know what's out there, what's not out there. So they can vote to say that there, in the absence of the evidence of the rigor that we're asking for, they can have an exception to that. And the measure then goes on to the next criterion. And the next criterion is looking at the opportunities for improvement.

CO-CHAIR HANRAHAN: Aline.

MEMBER HOLMES: I'm just asking NCQA does have patients that are medical home certification process. They have standards and guidelines. Wouldn't that be an acceptable augmentation for this, or I mean alternative to this? Because they do have a whole website with all kind of resources and certification. And this is nationally recognized. I know CMS reimburses, at least has some practice doing

that, using them.

MS. ANDERSON: We have discussed the importance of patient-centered medical homes with this workgroup.

MEMBER HOLMES: I can't hear you.

MS. ANDERSON: We have discussed the importance of person- and patient-centered medical homes previously with this workgroup and they've largely been supported as one of the strategies that can address quality improvement and support quality improvement for the population. However, I don't have any measures to offer you as alternatives of patient-centered medical home demonstration at the primary care practice or provider level outside of 0005.

So there are certification programs in place. And we could revisit that at a future date. But we don't have certification programs that we've necessarily included in the family, is the word. That wouldn't really be the -- it's more focused on measures.

CO-CHAIR HANRAHAN: Any other

discussion?

(No response.)

CO-CHAIR HANRAHAN: We're ready to vote.

MS. AMIRAULT: Okay. So for Measure 1909, voting for removal from family of measures, one being yes, and two being no.

(Vote.)

MS. AMIRAULT: Okay, 14 for yes, remove; 3 for no. 82 percent for removal from the family.

MS. ANDERSON: Thank you.

The next measure to consider is a little bit of a twist, an exciting twist. The Measure 0201, Pressure Ulcer Prevalence, Hospital Acquired, is -- has endorsement removed because the steward is no longer maintaining the measure.

This measure has available alternatives to consider. That's the exciting twist, if you missed it.

So the total number of patients that have had hospital-acquired nosocomial infections

of category Stage 2 or greater pressure ulcers on the day of the prevalence measurement. It's a risk adjustment outcome measure. And it's specified for hospitals and PAC/LTC settings.

And four members of the workgroup voted that this was a high priority measure. Could be important for screening measure, and pressure ulcers are an important clinical condition that can lead to institution and spread of severity and disability.

Two members voted that it was a low priority measure on the spirit of parsimony and because the endorsement has been removed.

Staff preliminary analysis is to remove the measure and consider available alternatives.

Would anyone like to discuss this measure before we consider available alternatives?

CO-CHAIR HANRAHAN: Yes, Clarke.

MEMBER ROSS: This is an example of an inadequate measure that some of us supported a

few years ago because of the importance of screening for pressure ulcers. Christopher Reeve died with infection of a pressure ulcer. And he had around 24-hour expert care and still didn't detect the pressure ulcer.

So many of these measures are for one setting and one population group and one time period which on the base of it's just not adequate. And yet where are the alternatives?

So I know there is a home health pressure ulcer measure because the home health providers on the PAC Long-Term Care voted against it because they didn't think it was worth it. Think it's only 6 percent of their clientele have pressure ulcers.

So my question is how many pressure ulcer measures are National Quality Forum endorsed? And what settings do they cover?

MS. ANDERSON: We will consider those in the next slide.

Any questions about 0201? Aline, is your card up or is that from before?

CO-CHAIR HANRAHAN: Megan, did you answer Clarke's question?

MS. ANDERSON: There are five measures in the next slide to pressure ulcers. Five measures to pressure ulcer on this slide. And we're on slide 84. And there is one measure on 0531, Patient Safety for Selected Indicators, which includes a component with pressure ulcers.

1789, Hospital-Wide All-Cause Unplanned Readmission. It is currently in the family but it is All-Cause Unplanned Readmission, even though there's not a focus on pressure ulcers, that I'd like for the workgroup to consider. That we're putting forward for you to consider, whether or not you like it.

And there is 0679, Percent of High Risk Residents with pressure ulcers.

And 0678, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, a short-care nursing home care measure.

And 0538, Pressure Ulcer Prevention Care which is a measure that's on reserve status

because there was a high performance across the population.

So these measures will be presented at this session for you to consider. And I can go forward with that at this time if there are no questions. Okay.

CO-CHAIR HANRAHAN: Thank you, Megan. That was great.

So we should go back and do a vote on the other one.

MS. ANDERSON: I'm getting the sense that the workgroup would like to consider the alternatives before voting to remove the measure that's no longer endorsed. Okay.

Should I go forward?

CO-CHAIR HANRAHAN: Oh, sure.

MS. ANDERSON: Okay, let's go to the next slide.

0531, Patient Safety for Selected Indicators. This is a modified version of the PSI90. This is a staff pick. And I will go through specifically why this measure rose to the

staff pick category.

This is a Patient Safety for Selected Indicators. It's a weighted average and reliability-adjusted, indirect standardized, observed-to-expected ratios for some indicators. It includes PSI03, Pressure Ulcer Rate, among others.

It's a risk-adjusted composite measure. And this workgroup has previously expressed preference for composite measures, measures that collectively represent quality with more than one element as opposed to individual measures because of burden.

It's also a measure of hospital and acute care. And you'll recall 0201 is a hospital-based measure. So this measure directly addresses the gap that that measure leaves.

It's also currently in use in hospital in-patient quality reporting and hospital value-based reporting programs. So this measure is in use currently in federal programs, which reduces the burden of additional measures.

So the staff analysis is to consider this as an alternative to 0201, Pressure Ulcer Prevalence, Hospital Acquired, because it's a hospital and facility based measure and used in several programs and addresses a wide range of safety issues relevant for the population.

Any questions?

MEMBER MONSON: So I was just taking a look quickly through them and I just want to make sure I read it right. So it looks like 0201 is Stage 2 and above and this one is Stage 3 and above. So can you help us understand why you think getting rid of Stage 2 pressure ulcers, which is still major issues, would be acceptable?

MS. ANDERSON: I am going to turn to my colleagues with nursing degrees.

CO-CHAIR HANRAHAN: I don't know. I mean it's probably the depth of the ulcer. You know, the severity of the ulcer. And I really don't know.

MS. ANDERSON: I am not an expert on pressure ulcers, I'm sorry to say. I think that

it is an NQF-endorsed measure and, therefore, the evidence has been enough that it was endorsed in this way. I am not versed on pressure ulcer stages.

Would anyone else like to comment?

CO-CHAIR HANRAHAN: I'd just like to say that what I like about this other measure is that it's focused on conditions that are most likely to have some kind of pressure associated -- - pressure ulcer associated. So one of the problems with pressure ulcer measures is that it's not -- it's a rare event.

So, yeah, go ahead.

MEMBER MONSON: So I'm not a clinician but I've spent a lot of time in LTSS and long-term care, post-acute care. And what I've seen time and again on our own internal measures is that if you don't, and what the providers have in the past said, if you don't pay attention to pressure ulcers you have not only hospital complications but then also in these populations it leads to institutionalization.

And so I would have to say I'd be very troubled about ignoring Stage 2 pressure ulcers because Stage 2 pressure ulcers from what I understand -- again I'm not a clinician -- are indicative of bigger problems too. Because that means that you -- that means something is going on in that facility that they're not paying attention to whether chairfast or bed-bound patients.

And for this population, to ignore that especially, again especially for this population I think would be a big mistake.

MEMBER WARSHAW: Yeah, I think Michael's concern is legitimate. I think that a Stage 2 ulcer means the skin is broken. Something's happened that puts the person at some risk and it could move to a Stage 3 or 4 pretty quickly.

I think the other issue with this measure, I understand the convenience of having a measure that has all these components to it but we've made some progress on pressure ulcer

reduction in hospitals but if you bury it in this kind of measure, I'm not sure how the measure gets reported out, but is there, is it a cumulative success with this? Or if you fail in one portion of this do you fail the measure?

Like let's say you're great at everything except pressure ulcer reduction, would you still pass this measure?

MS. ANDERSON: My understanding is that indicators are available for monitoring patient safety and improvement and things like that but that there is a composite measure that does report indicators. I would have to do more looking to see how accessible that is.

MEMBER WARSHAW: I agree that, in summary, that we shouldn't accept Stage 2 pressure ulcers in hospitals, and that if this doesn't allow for the providers to see where they're having errors and that somehow they're reflected in the reporting and this may not be sufficient to replace the one that we're going to get rid of.

CO-CHAIR HANRAHAN: Aline.

MEMBER HOLMES: Just to answer his question. You can report these indicators separately, pressure ulcers, PSI, separately for value-based purchasing, and it gets rolled up into this bigger measure. But a lot of Stage 2 is probably reported on this measure, statewide reporting, so it's available just for that one measure.

MEMBER RASK: Yeah, I was going to follow up, make the same comment about the PSI90. When it's rolled up in the other, in the value-based purchasing and other programs, these different outcomes are weighted. So the different outcomes of pressure ulcers is actually weighted pretty highly. So it's not just a pure rate of it, it's a proportion of what is your rate of pressure ulcers, and then weighted and then it is risk adjusted. So it does get rolled up.

I think the issue of the pressure ulcer 2 versus 3 is important. I think in terms

of a claims-based measure, the issue is, it's claims data, it's not a physical exam. And so that's why it's more reliable as a level 3. It's not saying that the level 2, Stage 2 isn't important, it's just a validity and reproducibility issue.

You know, I think the benefits of this are that it focuses at the hospital and acute care facility level. The benefit of some of the other ones that are considered are that they are a little bit richer in terms of what they're going to offer clinically, but it's not in this hospital setting.

And, you know, as somebody who's done a lot of quality improvement work in hospitals, I think that there you find, if I were trying to speak for them and so to speak for them I'd say that on the one hand they'd say, okay, you picked this. Thank God it's something else you're not asking me to do. It matches something I'm being required to do for another program; I'm very happy.

But then I'm also going to say claims data is claims data. And what I see on a patient and what I see in their claims don't always match up.

MS. ANDERSON: And that was also described in the endorsement report from 2015 that the committee was concerned about the use of claims-based measures, claims-based where there's measure reporting. However, they did endorse it as it is specified understanding that.

CO-CHAIR HANRAHAN: Gregg, did you want to say something? Okay.

Michael.

MEMBER MONSON: Fine. Because when I looked at I didn't see it as claims. I thought it said electronic. I didn't think it was claims, I thought it was EMR data that was, electronic clinical data is what it says here as the data source. So I just want to, I do want to clarify what -- oh, maybe I'm reading it wrong. I'm just reading what was on our worksheet. On our worksheet. That's my source of information,

so.

MEMBER HOLMES: It's claims data. That's where they pull it from. But it's based on the code -- the physician when he's completing the discharge form how properly identifies the pressure ulcer. Then they can pull that information code that this comes right from claims data. But it is based on what the physician documents at discharge.

CO-CHAIR HANRAHAN: Okay. Let's move to vote.

I thought we were going to vote on a previous slide and whether we will support the removal as an endorsed NQF measure.

MS. ANDERSON: Okay. So I would need a workgroup member or I'm getting from the group here I think that the vote is to remove 0201 as a measure that is no longer endorsed and replace it with 0531, Patient Safety for Selected Indicators.

We've got the vote at hand. There are five.

DR. MUKHERJEE: I think it might be helpful if we vote just to see, you know, the pressure ulcer, and then go through the five to see if any of the five, if one is moot, you know.

MS. ANDERSON: This is one of the five. Shall we move on to the others to look at them?

CO-CHAIR HANRAHAN: Sure.

MS. ANDERSON: Okay, let's do that.

So the next measure is 1789, Hospital-Wide All-Cause Unplanned Readmission Measure.

This measure is currently in the family of measures and does not include a specific element of pressure ulcers but is a hospital-wide unplanned risk standardized readmission rate within 30 days of hospital discharge.

Again it's a facility-level outcome measure and it is currently used in three separate programs: Medicare Shared Savings, Inpatient Hospital Quality Reporting, and Meaningful Use.

Are there any questions or discussion about this measure? Seeing --

MEMBER WARSHAW: It seems like a good measure. It's in our family but it doesn't really address the pressure ulcer issue. I mean because many of these will be fixed in the next setting, in the post-acute setting, so they'll never come back to the hospital. But it doesn't tell you what the hospital did.

MS. ANDERSON: Okay. Moving on to the next slide.

0679, Percent of High Risk Patients with Pressure Ulcers, Long Stay.

So this percent of long stay residents are identified as high risk for pressure ulcers in nursing facility who have one or more Stage 2, Stage 4 or unstageable pressure ulcers reported in the target MDS assessment during their episode during the quarter.

High risk populations are defined as those who are comatose or impaired in bed mobility or transfer, or are suffering from

malnutrition. Long stay residents are in at least 101 cumulative days of nursing facility care.

The measure is currently used in Nursing Home Quality Initiative and Nursing Home Compare programs. And the staff analysis is to consider it as an alternative because it does address the pressure ulcers directly but it is really limited to these high risk residents and does not address hospital-acquired pressure ulcers.

It also uses electronic clinical data that addresses burden and is used in federal programs which address the alignment.

CO-CHAIR HANRAHAN: One of the most obvious observations is that the pressure ulcer, the 0201, is hospital based and this is nursing home based. So I'm not sure you can replace one for the other.

MS. ANDERSON: Next slide.

MEMBER RASK: And I'd argue that they'd be two -- they're complementary measures.

MS. ANDERSON: So 0678, Percent of Residents or Patients With Pressure Ulcers that are New or Worsened, Short Stay.

So this is a percent of patients or short stay residents with Stage 2 risk to stage 4 pressure ulcers that are new or worsened since admission. They are a risk adjusted outcome measure collected via clinical data. Specified for in-patient rehabilitation facilities, long-term care hospitals, nursing homes and facilities.

It's currently used in several programs for those settings, including the IRF Quality Reporting, LTC Quality Reporting, and Nursing Home Quality Initiative and Home Compare.

Staff analysis, it's considered as an alternative. Specified for multiple long-term care settings but does not address hospital-acquired pressure ulcers.

It's a risk adjusted focus on high risk residents -- sorry, it does not focus on high risk residents. It's risk adjusted, uses

electronic clinical data, and it's in use in multiple programs.

Questions or discussion about this measure?

MEMBER MONSON: I would just say that this is the analog to the hospital one; right? Short stay. You know, 25 days in the nursing facility on average. So this would be the analog to the hospital one at 0201, except that it's clinical, it's MDS based but I don't think there's anything comparable for the hospitals.

MS. ANDERSON: Okay. The next slide is 0538, Pressure Ulcer Prevention Care.

It's a percentage of three components. Since we developed the materials this measure has been put into reserve status because it is high performance. So while it is presented in front of you as something to consider, I would note that it is reserve status endorsement.

Perhaps nursing can help me. Reserve side is something not -- the committee that recently reviewed this measure noted that it has

high performance across populations. And the recent data is 90 to 95 percent compliance and success reporting with this measure in reporting.

Therefore, we focus on using available resources on areas that do have opportunities for quality improvement. And because they is such high success with this measure we're looking to continue to identify other areas where quality improvement needs to be made and energy focused that way. Home health.

CO-CHAIR HANRAHAN: Discussion?

MEMBER RASK: My concern with it is besides home health and also it's a process measure where some of the others are really outcome measures. And if we have the opportunity for outcome measures, that what actually is the incidence of pressure ulcers versus are you documenting appropriately, I'd prefer an outcome versus documentation.

CO-CHAIR HANRAHAN: Clarke.

MEMBER ROSS: But I think this is the only measure for the home health quality

reporting related to pressure ulcers. So the fact is are we willing to stay let's excuse home health settings because of the weakness of the measure? Some of us are not willing to do that.

So we heard in the post-acute care long-term care only 6 percent of home health clients have pressure ulcers. So we're willing to risk 6 percent of the population having serious illness or dying.

So that's the problem with all these measures, they are limited to one little setting under a couple little conditions. But I'm not willing to exempt settings from such a serious health condition, even though it only affects, prevalence-wise, a small percentage of the population served.

CO-CHAIR HANRAHAN: Kim.

MEMBER RASK: To be clear, I wasn't saying we shouldn't measure it in home health. I'm saying I don't think this measure, to adopt this as a replacement for an outcome measure in hospital setting would be appropriate.

CO-CHAIR HANRAHAN: So the observation I have is that 0201 is hospital based. It is Stage 2 which is an earlier stage of identifying an ulcer.

The rest of them are site different.

So the question we have right now on the table is do we endorse NQF to remove the 0201? Am I right about that?

MEMBER RASK: The PSI90 is hospital specific.

CO-CHAIR HANRAHAN: Yes. But it also was Stage 3 and above.

MEMBER RASK: Stage 3, yes.

CO-CHAIR HANRAHAN: And it also was specified according to a particular diagnosis or condition versus 0201. Yeah, there was a whole - -

MEMBER RASK: Those were other measures that are included as part of the PSI90 along with the pressure ulcer measure. So it moves the pressure ulcer measure into being one of the composites, small free-standing pressure

ulcers.

CO-CHAIR HANRAHAN: Okay. I misinterpreted that.

MS. ANDERSON: So the question on the table is if we can remove 0201 from the family and if there is an alternative that the workgroup would like to use to replace this measure that's no longer being maintained.

I suggest that we take one decision at a time and vote first on the removal, now that you have seen the alternative. And then we would need a workgroup member to nominate one of the measures for addition to the family.

CO-CHAIR HANRAHAN: Aline.

MEMBER HOLMES: I just wanted to make a note, there is another alternative. NDNQI, which is the Nursing Database Quality Indicators, that's managed by the American Nursing Center, Credentialing Center, does have two pressure ulcer indicators that are used in house; both a prevalence and an incident measure.

The problem with it is that they are

not widely used across all. Any hospital that's going on a journey may use these measures. So it is more of a problem. It's not as widely done but it is more clinically based also.

Oh no, they're not National Quality Forum endorsed but they're -- I'm just saying there's other sources of this data.

CO-CHAIR HANRAHAN: Actually, NDNQI was absorbed by Press Ganey.

MEMBER HOLMES: I understand that.

CO-CHAIR HANRAHAN: Yeah.

MEMBER HOLMES: But I get that data as part of the HEN survey uses the exact same measures across.

CO-CHAIR HANRAHAN: They are using those measures?

MEMBER HOLMES: They are using exactly the same. Because I was getting it for our work before they went to Press Ganey and afterwards. So it's in this transition.

MEMBER AGUIAR: So I just have a question for the group because this is not a --

pressure ulcer is not an area that I am familiar with. And I'm not a clinical person.

But is it, is it more of a concern in a hospital based setting or the long-term care setting? Because it sounds like you have to choose between you're facing one that's hospital setting with another hospital setting or with one that's specific to nursing homes. And so if anyone has information on that, that would help me to make a decision.

CO-CHAIR HANRAHAN: Clarke, do you want to address that?

MEMBER ROSS: I just want to address it from the factor of a person who's paralyzed and uses a chair for everyday life. It doesn't make a difference where they are. They're at home.

Christopher Reeve was in his home with 24-hour care, the best in the world. And because he was paralyzed, no one caught the little pressure ulcer in his rear and it got infected and he died.

So some of it is patient characteristic. And this is -- so I work with a lot of professional people who use chairs and who are paralyzed. Every one of them have had pressure ulcer situations and every one of them is lucky it was detected early enough. Little, you know, dime-size red dot. And so maybe for other conditions the setting is important. A person who is paralyzed and uses a chair, doesn't make a difference where the setting is.

CO-CHAIR HANRAHAN: I think hospitals because the stay is so short, the length of stay is so short, it's very unlikely you're going to develop one that you can attribute to that hospital stay. But I think what Clarke is saying is no matter where it is, it's a really significant neglect in care and process.

Go ahead, George.

MEMBER ANDREWS: Yeah. In answer to Christine's question I would say that you have even in an acute setting situations where you are there lying facing upwards for a long time,

especially if you're in an intensive care unit and you have multiple lines. And because of the lines or for no reason you may not be moved or turned, even though they try to. So you are at the higher risk for developing, if you are there three weeks, four weeks, which is not uncommon, to develop the stages of an ulcer.

So it would apply even though it's not to the level that you would see in a long-term care facility.

MS. ANDERSON: And I would just add that while I said to replace with one measure, I mean to vote on one measure at a time. The workgroup may choose to have more than one pressure ulcer measure in the family. And it could be for different settings, but we need to vote on them each one at a time.

And I would also emphasize the measure selection criteria specifically emphasizes parsimony. We already have 76 measures in the family. We did move a few. But adding two to replace one is something to take in mind. And

that's my reminder of parsimony for the workgroup members. And I ensured that I remember that.

That's the process. Administrative note.

CO-CHAIR HANRAHAN: Kimberly, you want to say something?

MEMBER RASK: Alice pointed out very wisely to hold up the exclusion criteria for the PSI90. And the notion that what we're -- since our specific focus is dual eligible in that patient population, what I would ask, and many of the group here who have more experience than I do on what would be more relevant for this patient population, but for the PSI90 in the hospital setting you exclude high risk people, which means you exclude anyone with an ICD-9 close for hemiplegia, paraplegia, quadriplegia, spina bifida, brain damage, debridement, pedicle graft, major operating procedure, transfer or transfer to skilled nurse facility.

And so after reading that I'm kind of wondering rather than the PSI90 for dual

eligibles, might we be better off with one of the other measures that's using MDS in a long-term care facility rather than the PSI90?

CO-CHAIR HANRAHAN: This is the 0531.

MS. ANDERSON: We will first take a vote -- out of clarity I'll say we'll first take a vote to remove 0201 from the family. It sounds like we, the group is, has available alternatives that they appreciate as an alternative to that measure. So I think we -- at time that we can take that vote. And then we will vote on the inclusion of alternatives to 0201.

Is that, is that accurate? Okay. We will go to the vote.

Okay, Janine, vote to remove 0201.

MS. AMIRAULT: Okay. So for 0201, for removal from family of measures, one being yes removed, two being no.

(Vote.)

MS. AMIRAULT: Okay, so we have 11 for yes, remove; and 6 for no. And based on the 65 percentage, the consensus is to remove.

MS. ANDERSON: Thank you.

CO-CHAIR HANSEN: We're teaming up here in the process of going back then to looking at the other alternatives that we discussed and to see if one of those measures rises more to the top that we would like to choose to vote on. So, and is there somebody who would like to propose, given the discussion that we had on slide 84, the six -- excuse me, five items that we have?

MEMBER RASK: I would like to propose that we consider adding the 0678, the residents or patients with a short stay, which seems closer and similar. It's based on MDS data which will be a little bit richer and it would be more appropriate for, probably more relevant for our dual eligibles than what it's replacing.

CO-CHAIR HANRAHAN: Any other comments?

MEMBER MONSON: So if -- I'm disappointed about the other one, but let it go -- so if we're going to move away from the hospital, then a short stay in a nursing facility

is probably the wrong place for us to focus, especially with the way the policy environment is moving and the payment environment. We're going to see a lot fewer patients going through nursing facilities for rehab.

Not that there won't be a lot -- there won't be some but it will be much lower than it is today, which would then indicate that if you want to capture it you would want to do the long stay measure in nursing homes and then maybe some modified home health measure to capture the short stay folks.

MS. ANDERSON: So I'm going to briefly review 0678 and 0679 for the workgroup benefit.

0678 is described in slide 88. It is Percent of New -- of patients of -- Percent of Patients or Short Stay Residents with Stage 2 to Stage 4 Pressure Ulcers That Are New Or Worsened Since Admission. It's a risk-adjusted outcome measure collected via electronic data, specified for IRFs, LTCs and nursing homes, and currently used in three programs for those settings.

The alternative that's been proposed is 0679 or also has been proposed for addition to the family is 0679, Percent of High Risk Residents with Pressure Ulcers, percent of high risk residents which are individuals who are comatose or impaired in bed mobility or transferabilities, or suffering from malnutrition. And those high risk residents who have one or more Stage 2 to Stage 4 or unstageable pressure ulcers reported in the MDS data. It's specified for nursing home facilities and currently in Nursing Home Quality Initiative programs.

CO-CHAIR HANRAHAN: Discussion?

Gregg.

MEMBER WARSHAW: I think that both these measures, I believe that it's important to identify quality of care around pressure ulcers in all settings and in all circumstances. So I think a short stay one, although I agree to where the trends are going, it does also reflect pressure ulcers that are identified in that

setting that get worse.

As most of you know that work in this area, because of the quality measures, nursing homes are much more aggressive to examine skin at the time of admission from hospital. I mean it is possible to identify even damage that hasn't appeared yet. They take pictures and they are making sure that it's clear that this is something that happened in the hospital, not in the nursing home. And then we deal with it from that point on.

So being -- keeping people alert to examining the patient when they come in and being alert to making sure that things don't get worse during the stay in the nursing home or in the post-acute setting is a good, is a good measure. And so I think the short-term one is a good one.

And this long-term measure is another quality measure based on people who are bed bound for long periods of time. And they're not duplicative. They're both important.

So I realize we don't want to have too

many measures but they're both important.

CO-CHAIR HANRAHAN: Shall we vote?

MS. ANDERSON: Okay, first we'll vote on the inclusion of 0678, Percent of Residents or Patients With Pressure Ulcers That Are New Or Worsened.

We will take a second vote that is independent on 0679. So it may be that the workgroup votes to include both of them or that it votes only to include one. But we're not comparing them in the voting; we compared them in our discussion. Is that sufficient?

MEMBER WARSHAW: Yes.

MS. ANDERSON: Okay. So 0678 is the vote. And the vote is to include it in the family.

Janine.

MS. AMIRAULT: Okay. So for 0678 for addition to the family of measures, one being yes, two being no.

(Vote.)

MS. AMIRAULT: Okay, so for 0678 to

the addition to the family of measures, 15 for yes, 2 for no. Based on the 88 percent consensus, to be added.

MS. ANDERSON: Now we will vote on 0679 which is Percent of High Risk Residents With Pressure Ulcers, Long Stay.

MS. AMIRAULT: Okay. So for 0679 on the addition to the family of measures, one being yes, two being no.

(Vote.)

MS. AMIRAULT: Okay. So for 0679 we have 16 for yes to be added to the family, and 1 for no. Based on the percentage, consensus is to add this to the family.

CO-CHAIR HANRAHAN: Michael.

MEMBER MONSON: So I think these are great measures. Very happy that they're in.

But I do think that there's maybe another measure gap that we have here which is all these measures, with the exception of the long stay measure which is only going to capture a small percentage of the population, are really

acute or post-acute measures. And so we've got the vast majority of people who are dual eligibles who are out in the community receiving HCBS services and we have no measure around pressure ulcers or wounds for them.

And I think to build on what Clarke was saying, I mean that's when Christopher Reeve had his issue. And that's when people end up with wounds and went back to a hospital or into a hospital or end up institutionalized. So I don't think we have a validated measure right now for HCBS individuals on Medicaid on long-term services reports. And I think that that's a big gap.

MS. ANDERSON: We think that's a great question and point of discussion for tomorrow's presentation on the ongoing HCBS project as well.

So we are on slide 91, and we're going to consider measures that have been newly endorsed in the family. There are six newly endorsed measures of health and well-being. And the staff preliminary analysis for these measures

was not to recommend since they are condition-specific and do not address priority area.

For cardiovascular medication measurement, ACE inhibitor, ACE/ARB measure.

Three measures for end-stage renal disease which so those measures were condition-specific.

There was also staff of measures that are not appropriate for the population because they are pediatric measures. So there are two measures of pediatric care.

Does anyone have any discussion or questions about these measures?

(No response.)

MS. ANDERSON: Hearing none, we will move on the next slide of four newly-endorsed measures that the staff preliminary analysis is not to recommend them because they are condition-specific and do not address priority areas for the population.

Those measures are carotid artery stenting; statin use in persons with diabetes;

average change in functional status following lumbar spine fusion surgery; and average change in functional status following total knee replacement.

And we'll, just as a reminder, we'll be considering functional status measures later this afternoon.

CO-CHAIR HANRAHAN: Megan, a question. Are you saying they're not endorsed because, did you say because they're condition-specific? Does that mean that these are measures that are elsewhere and we're not endorsing them specifically for the dual eligibles?

MS. ANDERSON: These are newly-endorsed measures. These are newly-endorsed measures that have been endorsed by NQF Steering Committee that the measure applications partnership can consider for inclusion to the family for dual beneficiaries. And as staff building on previous recommendations from this workgroup, we've looked at them and determined that they do not address the priority gap area,

or that they are condition-specific.

And but we also -- and that there are other measures in the case of the diabetes or other measures, more comprehensive diabetes measures in the family that we did not perceive that see they would be preferred over the measures in the family.

CO-CHAIR HANRAHAN: So George and then Kimberly and then Joan.

MEMBER ANDREWS: Yeah, just to clarify. Is the recommendation from the staff that, for example, the cardiovascular angiotensin inhibitors or ARBs, this particular measure be removed because it does not --

MS. ANDERSON: It's not being removed from anything. It's not in the family. It's a brand new endorsed measure that is highly condition-specific. And we wanted you to be informed of the newly-endorsed measures. And as staff we don't have the authority to say that they don't belong in the family. And this is maintenance of the family.

So if you would like to bring them for discussion for inclusion in the family, you have the opportunity to do that.

MEMBER ANDREWS: Yes. As I'm looking at the measures of health and well-being, we do know health and well-being relies a lot on prevention. And ACE inhibition therapy in diabetics for prevention of renal disease are being used in diabetics the same. ACE used in hypertensives, particularly if they have diabetes, very strongly recommended. ACE or ARB used in heart failure.

So if we're talking about somebody's well-being being well-contained and improved, you're not going to be able to achieve without these medications. So for me these are must-have medications in cardiovascular disease management and for wellness and well-being.

MS. ANDERSON: Primarily these measures were endorsed, the first two were endorsed under the cardiovascular project. But measures of health and well-being were on the

other side. Just how they were broken up.

If you would like to bring them forward for consideration for inclusion in the family, which it sounds like you do, we can discuss that.

MEMBER ANDREWS: Yes. The answer is yes.

MS. ANDERSON: Okay. All of them or -- all of the four measures on this slide or the top two, George?

MEMBER ANDREWS: My statement was specific to the first two.

MS. ANDERSON: Okay.

MEMBER ANDREWS: I'm sorry, yes, health and well-being. Yes, 1662.

MS. ANDERSON: Okay. Okay, I don't have a slide prepared on that but we will discuss it.

There are other cards up, however, so would we like to move on to discuss that measure or would you like to share your thoughts? Others?

CO-CHAIR HANRAHAN: Kimberly.

MEMBER RASK: One other has raised the issue on the statin and the diabetes one. And I don't know if -- I mean I'm wondering if some of these require enough information and looking around the path is that something -- being a first time here at this group I don't know to what extent these things can fit into the purview of what we're covering right now.

But thinking both about the cardiovascular and the diabetes, I know that there are other composite measures for diabetes care. And so to some extent it may already be included in there but with the statin being a new one I'm also thinking in dual eligibles with co-existing behavioral health and medical conditions and the high rate of diabetes and cardiovascular disease, is that something that's of particular importance for dual eligibles that we might want to consider measures that do get into cardiovascular disease and diabetes.

And I don't know, that's my lack of

knowledge, to what extent the clinical measures that are already part of the family might incorporate that or whether there should be an opportunity for us to bring in some measures that would be relevant.

DR. MUKHERJEE: So we do have 0018 which is Controlling Blood Pressure, and it's controlling blood pressure with the purpose of ESRD and controlling or preventing ESRD, end-stage renal disease.

So we do have one. It's an outcome measure. It's endorsed. And it's control of hypertension with medication. It doesn't specify ACE, ARB or statins, but it goes with the blood pressure ranges. So there is one, and it's 0018.

CO-CHAIR HANSEN: And I believe tomorrow morning we'll be actually considering some of the well-being measures. So this will continue.

MS. ANDERSON: So I think your observations are right on. Where I don't have this information at my fingertips -- I have them

at my fingertips but I don't have it ready to present. So what we did in the staff preliminary analysis was to look at all of the available newly-endorsed measures. And as staff, it's important that we -- that we show these to you, and this is a perfect example of why.

We have other measures that do address cardiovascular care and diabetes care that are more comprehensive or are already included in the family. And so the staff preliminary analysis takes that into consideration, took into consideration burden, parsimony and the priorities of the workgroup. It did not recommend the measures for consideration for inclusion in the family.

Because of your interest in them, what we can do is this evening I can prepare slides on these two measures for consideration tomorrow morning for inclusion in the family. And then I will be able to have information about the use of them in other federal programs. However, because they are brand new measures, newly endorsed, it's

unlikely that they are used in federal programs or are otherwise aligned.

And so I'm happy to do -- we're happy to do that overnight and, if that is satisfactory, for the workgroup to consider them tomorrow morning.

So I have 1662 as one measure that we're going to consider tomorrow morning. And is there another measure? 2712, Statin Use in Persons With Diabetes.

Are there any other measures the workgroup would like to consider for addition to the family tomorrow morning?

(No response.)

MS. ANDERSON: Okay. We are close to on time, which is great. Thank you all. We need to go to public comment at 3:00. And that is what time it is.

CO-CHAIR HANSEN: Operator, would you please let us know if there are any members of the public who would like to ask questions and make comment, and those also who are in the room.

OPERATOR: Yes, ma'am. At this time, if you would like to comment, please press star then the number one.

(Pause.)

OPERATOR: There are no public comments from the phone line.

CO-CHAIR HANSEN: Thank you, Operator. There are some other measures on safety. And if you would go to slide number 93.

MS. ANDERSON: So while the staff preliminary analysis had ruled out the measures, and we'll bring two of them back for you tomorrow morning, we did -- Jim, do you have something you'd like to add? No.

Okay. We did bring additional measures for your consideration on patient safety. There are three measures on slide 93 for your consideration, two of which the staff recommends that you consider for inclusion in the family, and a third which was condition-specific. But because they are the three patient safety medication measures, we will present them

together.

The first is 2720: National Healthcare Safety Network Antimicrobial Use. The preliminary analysis considered it for addition to the family because it addresses an important area for patient safety, structure and culture. It does not address high-leverage opportunity for measurement or priority gap area directly.

And 2723: Wrong-Patient Retract-and-Reorder measure, which is a staff pick because the preliminary analysis is to consider it for addition to the family because it is an outcome measure and addresses patient safety, structure and culture, but does not address the high-leverage opportunities and the gap areas as specifically as some of the other measures we considered earlier this morning -- excuse me, this afternoon.

CO-CHAIR HANSEN: Megan, I know there is a definition here. But since we're meeting in person would you put some more texture to that patient retract-and-reorder?

MS. ANDERSON: In two slides.

CO-CHAIR HANSEN: Right, sorry.

MS. ANDERSON: So the next slide is 2720: National Healthcare Safety Network.

It's a measure that assesses antimicrobial use in hospitals based on medication administration data that hospitals collect electronically at the point of care and report via electronic file submissions to CDC.

And it's a risk-adjusted process measure. It's specific for hospitals and acute care facilities, in-patient rehabilitation facilities, long-term acute care hospitals.

And it is a patient safety measure that addresses structure and culture but does not address one of the specific six gap areas that this workgroup has previously listed.

Does any workgroup member have questions about this measure?

(No response.)

MS. ANDERSON: Okay. Gregg, is your card up? Gregg, is your card up?

MEMBER WARSHAW: No.

MS. ANDERSON: No. Okay.

The next measure is 2723: Wrong-Patient Retract-and-Reorder measure. It's an event -- it's when an event occurs as an order is replaced -- is placed on a patient in an EHR, is retracted within ten minutes, and then the same clinician places the same order on a different patient within the next ten minutes.

It's a rate calculated by dividing the wrong-patient reorder -- retract-and-reorder event by the total orders examined. It's a risk-adjusted outcome measure. It's specified for clinician, integrated delivery systems, and it's collected from electronic medical records.

And we wanted to recognize that there is a related medication measure in the family currently. It's 2456: Medication Reconciliation, which is the number of unintentional medication discrepancies per patient. So we have a medication measure that is medication discrepancies per patient in the family

currently, and we'd like the workgroup to consider and discuss the inclusion or the replacement of that measure with these alternatives.

Is there any workgroup discussion on 2723?

CO-CHAIR HANSEN: Given the fact that there is another measure, the staff now recommend this one, could you share what some of the benefits of this might be over an existing one?

MS. ANDERSON: I don't know that I would. I didn't compare and contrast the two measures, but of the newly available measures, if the workgroup wanted to consider them, this would be one of them. I am happy to look up 2456.

(Pause.)

MS. ANDERSON: And 2456 is an outcome -- NQF-endorsed outcome measure. It is Medication Reconciliation, Number of Unintentional Medication Discrepancies Per Patient. It is a measure that assesses the actual quality of medication reconciliation

process by identifying errors in admission and discharge medication orders due to problems with medication reconciliation process. The target population is any hospitalized adult patient and the time frame is within the period of hospitalization.

It is not risk-adjusted. It excludes patients that are discharged or expire before the gold standard medication list can be obtained. It addresses National Quality Strategy priority of effective communication care coordination.

It is specified for a hospital level of analysis -- excuse me, hospital care setting and facility level of analysis. It is also collected via electronic clinical data. And it is included in the CMMI priority measures for monitoring and evaluation, hospital in-patient quality reporting, hospital value-based purchasing, and physician-based quality -- physician-based value -- physician's value-based payment modifier.

So the measure that's currently in the

family is an outcome measure for hospitals that is currently in federal programs and is electronically collected.

MEMBER HOLMES: I just have a question about it. Do we know how many of the electronic health records systems actually have this capability that are out there? I don't know how -- unless it was programmed into it.

MS. ANDERSON: I don't remember the number but the retract-and-reorder measure I think, I recently read the report, and that was a concern from the Endorsement Committee. However, they noted that the trend and the strong encouragement is for development and implementation of federal programs -- or of electronic records for the future. So it's a forward-looking measure.

And the measure that is previous to this one, 2720, is also limited but it's an NHSN so it's a CDC measure. Again, not everyone's using it. But the people who are -- the programs -- facilities that are participating are using

it, but it's not in any federal programs per se. It's in the CDC collection, data collection.

MEMBER HOLMES: I just -- based on what I know is a lot of the hospitals in our area that's not something that they're tracking right now. So that's why I asked the -- they're tracking medication reconciliation because it is a requirement for CMS and Joint Commission, but I'm not sure that that's something that's even built in. I'd have to even find out how to do it.

And then there's a question about -- we don't have any, but there are a lot of critical access hospitals that have very minimal electronic health records systems.

MEMBER STUART: So I think the majority of medication errors occur in the admission and discharge processes where the transfer of that information is not well done. And, you know, I'd be curious to know how many within this short time frame, ten minutes, given the limitations of all of this, if it's future-

looking then maybe we should hold it to the future when we have a little bit more evidence around it and stay with the measure we have.

CO-CHAIR HANSEN: Kimberly.

MEMBER RASK: I really see them as two different measures -- or that they're measuring two different things; sorry. So I think, you know, MedRec I think also has a lot to do with care coordination, along with not making mistakes, but how are people communicating?

And this is more of an almost -- what do you call it? A counterbalancing measure where you're kind of saying, okay, we are moving to electronic health records but there are now some concerns about mistakes that happen with folks using electronic health records and the screens and what's available and what's not.

And this is kind of measuring that sort of problem, which is something different from care coordination or from MedRec. I mean, this order could be a test. It could be a x-ray on the wrong person. I'm assuming as I read it,

it could be -- it could be any number of things.

So I think that it may be forward thinking in terms of the number of places that could calculate it right now. What I do like about it is it becomes a way to be able to make sure that as people are moving and putting new processes, just because you make it electronic doesn't make it necessarily better. You might build in more mistakes and this becomes a way to kind of monitor what the rate of that is and are there in fact -- you know, this is like being able to -- one of the few times in healthcare where we can get the near miss. We usually get the full miss.

And this would be a way to electronically get a near miss without it being as resource intensive as having to do chart review or hope that someone would anonymously report it.

CO-CHAIR HANRAHAN: Gregg, did you have your --

MEMBER WARSHAW: Yeah, I agree with

all Kimberly's comments. And I think this particular -- the medication reconciliation is critical across the continuum. And I couldn't quite follow the measure discussion but I'm sure we'll have more measures that talk about medication reconciliation.

This is different. This is an EHR kind of opportunity to try to, as you're describing -- this would really be like if this was too high then you'd want to start looking for the ones that weren't corrected in ten minutes.

I mean the fact that it's retracted in ten minutes means no harm was done. So that's actually a good thing. You just didn't want to have too many of these going on because then it means some of them probably weren't caught.

So this measure is interesting but I'm not quite sure I can fully wrap my head around it yet. It is pretty serious.

CO-CHAIR HANRAHAN: I say ditto. It's I'm having a hard time wrapping my head around the significance of this. I mean, what if I

write in the record, you know, make a note and I just -- it's something, there's nothing, like it's a few words. And I go to the next record and then it's counted as a -- you know, a retract-and-reorder and somehow there's some punitive response to that. I mean it's just too loosey-goosey about what it is about.

MEMBER WARSHAW: Well, it is true that in the electronic health record when you sign an order it goes into the system. And some systems it's easier or harder to retract. But I guess -- I work mostly in the out-patient setting, but when I make a mistake in the out-patient setting, I have to work really quickly to retract it. And it is easy to make mistakes, but the important thing is that they're identified quickly and corrected.

MS. ANDERSON: The Steering Committee worked with the developer and steward to understand that this measure should be used for quality improvement and not for payment until further understanding -- there's further

understanding about the data. And that specifically the measure should not be used to punish clinicians and providers. I'll just interject that commentary from the Steering Committee.

MEMBER BUHR: And I would agree with what's been said in that to me it doesn't seem like it's an outcome measure but it's not measuring an outcome that I really care that much about. I mean it's not -- it's a good thing if you're catching it, like Gregg said. So I don't know. I don't know.

Like, you know, as an example in an out-patient setting, my father-in-law recently went to the Urgent Care and went to the pharmacy and came home and he had two antibiotics. And the discharge instruction said to take one of them but he had two different ones in his pharmacy bag and so that didn't get caught. They obviously changed their mind or something but they didn't retract the first one.

So that's a worse outcome. It would

be better if they had retracted it. So, I don't know, it doesn't seem like we should put that much energy into this measure.

CO-CHAIR HANRAHAN: Thank you. I think we're at a stage where, you know, this is a different category. It's a near miss. It's a quality improvement component. What I've heard is that somebody -- some people feel it might be a little premature. On the other hand, some, you know, feel that it might be a good QA procedure.

What we need from a process standpoint right now that, you know, it's not something we have to actually include, but we need a recommendation if we are from a workgroup member on the table so that the larger group can vote upon it. So is there a nomination of this particular measure at this time?

Oh, I'm sorry, Tom. I forgot. I didn't see you.

MEMBER LUTZOW: Yeah, I'm surprised at the level of staff enthusiasm around this measure. My question would be, not that it's a

bad measure, but does it rise to the occasion? Does it have the requisite weight to get our attention?

And aren't there other things of more importance that we need to be focused on than correct records. Unless there's some evidence that this is a rampant problem that needs fixing, I don't know, you know, what the evidence is. So how could you be so excited? You must have evidence that this is like a plague infecting the EHR system across the country.

MS. ANDERSON: I -- it was just a pretty straightforward calculation that had enough points. So there is -- it's a risk-adjusted outcome measure that crosses many different settings. And so -- and it uses electronic clinical data that didn't have a lot of burden for reporting.

So that, that is the rationale behind the staff preliminary analysis. And I'm not hearing a nomination to include it into the family of measures.

I'm not hearing a nomination to include the others either, so barring none -- barring any, we can move on and we will do our work as staff to investigate the other two measures like this to bring forward for your consideration and inclusion in the family in the morning.

We will conduct a brief break. We will make sure that our next presenter is on the phone, and we will talk about a person- and family-centered care NQF endorsement project next.

So I would ask you all to return to your chairs at 3:30, and that's it. You get a break. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:17 p.m. and resumed at 3:30 p.m.)

CO-CHAIR HANSEN: So, we are actually going to move into the whole area of person-centeredness that has been an important focus for our MAP, and this is one of those examples where

we have the opportunity to get cross-fertilization.

So, there is some recent new measures that have come out from this MAP group, and we're really happy to have our colleague here have a chance to speak.

And we are, I guess, going to have Sarah Sampsel. Okay, Sarah, I think I hear you on the line.

MS. SAMPSEL: Yes. Thank you. Hi everybody. My name is Sarah Sampsel. And I am calling in from New Mexico where I can typically report it's sunny and 70, but we've had a lot of rain lately. So, I can't even report that.

I am the Senior Director for the person- and family-centered care work, as well -- and so that is endorsement and consensus development project work or CDP project work. As well as the Senior Director for the MAP PAC/LTC Workgroup.

So, kind of a lot of cross-pollination, fertilization as was just mentioned.

So, what I'm going to do is provide a quick overview and update of the work of the person- and family-centered care standing committee.

Which has been back up and running since about 2013. It's a really active committee because there's a lot of interest in this area and I'll provide an update on where we are in the measure portfolio and some kind of key themes that we're hearing from the group.

But also realize that it's kind of hard to put two phases of work into just a couple of slides. But we're seeing some really exciting activity on the endorsement, both measure development and measure implementation side when it comes to first person- and family-centered care measures.

So, if we can go to the next slide. I thought it would be important to center everybody on the fact that NQF had a project a few years ago. I think it was in 2011/2012, where they pulled a panel together to formulate a kind of broad-based definition on what is person-

and family-centered care. And specifically ensuring that there's alignment with the National Quality Strategy.

So, our definition is an approach to the planning and delivery of care across settings and time that is centered on collaborative partnerships among individuals, their defined family and providers of care.

It supports health and well-being by being consistent with respectful and responsive to an individual's priorities, goals, needs, and values.

And so, you know, that's fairly broad-based. It's extremely crosscutting. You all have seen measures in other areas such as health and well-being, care coordination, et cetera that certainly could fall into this bucket as well. And so, as I go through the projects, you'll see we did some further, almost refinement of the type of measures that come through our portfolio. Next slide.

So our first phase was in 2014 and

finished up in 2015. In fact, very -- pretty early last year so that we could start our second phase, and in this first phase we recommended endorsement maintenance of ten measures, both maintenance and new measures. These were all focused on experience of care.

And so -- and I know in the past section, or two sections ago, you were talking about some measures that have had changes in endorsement status and that included some of the CAHPS measures.

And that was because of some of the work that came out of this committee that those CAHPS measures were not put forward for maintenance review. Therefore, they ended up losing endorsement. And that was continued back and forth discussion with the developers at that time.

However, during that first phase, we did endorse ten measures. Which included hospital CAHPS, incidence of hemodialysis CAHPS, as well as the care transition measure, the CTM-

3, which should eventually be migrated into the overall hospital CAHPS measurement sets. And there were also some measures on patient experience of psychiatric care. And some measures regarding end of life and hospice care.

In this part of the project, we also identified some themes regarding gaps in the portfolio, and frankly, I'm sure these are also things that you all have discussed in the past.

But, specifically measures and surveys that they must be relevant and inclusive of populations that speak languages other than English. So, how is that translated in a CDP project?

Well, this standing committee asked a lot of questions about the number of formats a survey may be available in if we're deriving measures from it and the level of testing if a measure developer comes forward and says it's translated into 43 languages.

Well, did the measure -- or do the questions and the items on the questions mean the

same? So that you would actually have valid and reliable measures when you report out those measures for top line scoring. Which a lot of these survey-based measures do.

Measures should be developed for other care settings including rehabilitation facilities. And remember this is specifically feedback on experience of care measures. And at that point, hospice CAHPS had not come through NQF. In fact that's currently under consideration by the palliative care project.

But, we were still seeing a lot of the CAHPS and experience of care level measures focused on facilities, whether it be psychiatric or acute care. You know, the end of -- I'm sorry, incident hemodialysis care. Again, it's a facility-based measure. Although it is a dialysis facility versus necessarily a hospital.

And so really kind of encouragement from the person- and family-centered care standing committee that they'd like to see these settings expanded and CAHPS measures -- or other

expansive care measures that are updated for other settings.

And then a need to -- there is a need to better understand commonly excluded populations and how their voices may not be heard across surveys.

So, for example, in I believe it's hospital CAHPS, maternity patients are excluded. And there was concern raised about that because obviously in a certain percentage of the female population, especially during the fertile age period, that might be the only reason a woman ends up in the hospital. So, we're missing all of that information. As well as -- you know, consideration of pediatrics.

And in a recent pediatric CDP project as well, there were a lot more expansive care surveys that came forward. So, I think we're slowly seeing these gaps being filled.

If we can move on. So, in phase two of the project, and we just submitted our final report on phase two, we actually looked at 28

measures and all of these measures were focused on functional status. We had a suite of measures from FOTO, which is the Focus on Occupational Therapeutic Outcomes.

And the FOTO measures were really about improvement in change score on functional status for patients with specific ailments. Typically, I think there was lumbar. There was neck and spine in addition. There were general orthopedics. There was hand and wrist. There was ankle. But basically, certain areas that might -- that showed some variation in how functional status changes over time with treatment.

We also saw the CARE Item process and outcome measures. So, as you may be familiar with, CMS has recently and over the past few years been working on the CARE assessment tool, and out of that they stated to develop measures. And some of these were setting-specific measures, whether they were for long-term care or inpatient rehabilitation facilities.

And then UDSMR submitted some measures that were derived from the FIM. Again, focused on self-care, mobility and overall motor skills for patients in specific long-term care settings.

So, with those first two phases, the table at the bottom of this slide just shows that currently we have 11 process measures and 59 outcome measures in this portfolio.

You know, I can't make any extreme predictions on what's going to happen. I can tell you in phase three of the project that our submission deadline just closed a week or two ago.

We have an additional 21 measures for review, which will expand the portfolio a little bit more. There are only nine measures up for maintenance review, and another 12 new measures.

And we'll be seeing some measures come forward with things like shared decision-making. We're currently in the process of finalizing endorsement and ratifying a measure on patient activation.

We have a lot of communication measures coming forward. And then we have some more FIM-based measures coming through this next cycle. So, the portfolio is continuing to expand. We're certainly seeing this to be an important area. Next slide.

So, in phase two, as I went back through the report and was thinking about, you know, kind of what you all would want to hear and what might be relevant to you, we did have some themes that came out of that report.

One of those has to do with parsimony in functional status measurement. And you know, we heard about -- we also heard that through the PAC/LTC workgroup as well, in that, you know, there's a strong need for measure alignment.

And in order to do so, then you really want the measures and the assessment tools that you're using to align across settings. So that's -- you know, that's one of the goals that we see coming across, and certainly with the measures that were submitted to us by CMS.

There is -- there was the need and continued need to acknowledge as new measures and new assessment tools are brought forward and even though they may have very good intent on improving measurement science, or improving assessment science, et cetera, there has to be some reflection and consideration given to the fact that some of these facilities, specifically the PAC/LTC facilities, have been using one tool for a long period of time.

And realizing one, you know, it's a switch in staffing. There is incredible training. There may be some financial implications as well, but it's not just a simple switch over from one measure to another or one tool or another. And some consideration to that in the process.

And then finally thinking about a common core set of items that could be used across settings. And so, there's a lot of discussion about the fact, especially with the FOTO measures, which was a series of seven

measures looking at seven different parts of the body, and joint areas of the body.

You know, is it really necessary to have a different assessment tool for each? And there's some pliant space to say that perhaps there is.

Perhaps you really do need one assessment for the back and a different for the knee, you know, in order to get to the right components of functional status, but I think all of that's still, you know, that's work outside of NQF. But certainly strong considerations that the standing committee brought forward and wanted documented in the report. Next slide.

So what I wanted to do now is quickly transition because both the person- and family-centered care work, as well as the PAC/LTC work, and then some of the measures that you have been considering and will be considering as we move forward, are kind of outcomes of the IMPACT Act.

And I can't say that I do this part of the presentation as well as my CMS colleagues.

But, I do think this is important for you to understand and have this background of, you know, that's why we had 28 measure in phase two.

That's why we'll have additional functional status measures coming through phase three of person- and family-centered care. And I'm sure more to come because we certainly saw additional ones coming through on the MUC list for PAC/LTC last year.

But basically, it's the Improving Medicare Post-Acute Care Transformation Act, or the IMPACT Act of 2014. So, it was signed on October 6, 2014, and with the goal of standardized patient assessment data that will allow uniformity, the ability to capture quality care and improve outcomes. The ability to compare quality data across post-acute care settings. To increase focus on discharge planning. Exchangeability of data, and coordinated care.

When I look at this full list, these all work hand in hand. And there's not one of

them is a unique characteristic in and of itself. You know, I think it's really important to acknowledge and understand that you really can't have improved discharge planning until you have that exchangeability of data and the coordination of care.

And so, as we've been looking at these measures and considering these measures through the CDP project, those are some of the things that we have to think about. Is okay, what is this doing to meet those intents, or meet that intent? And how does it all work together? Next slide.

You know, and I think some of this is a little bit, you know, even it takes us back to the next slide a little bit. In that there are driving forces of the IMPACT Act. And so, some of those forces included improving Medicare beneficiary outcome. There has been a lot of talk over the past few years, and actually -- there's been a considerable amount of action too, that tries to improve discharge planning, that

tries to improve transitions of care. And really, all of that was the intent to improve Medicare beneficiary outcomes.

There's also this need for provider access of longitudinal information to facilitate coordinated care. And with that, if you're measuring functional status at discharge from a hospital and using that same tool and able to compare the data from discharge to the hospital to say an inpatient rehabilitation facility and to home health, that's huge.

You can really see the trajectory of a patient and see where there might be some areas where you need to -- you know, where the providers either need to go back and find out more about what worked and didn't work in the past, or how the treatment plan may change in the future.

We've already mentioned enable the comparable data across -- comparable data and quality across PAC settings. And all of these, I think, lead into that improved discharge planning

and then research.

And you know, I think in the work that we do with our CMS colleagues, working on the implementation of the IMPACT Act, and specifically the development of measures and implementation of assessment tools, you know, that really is something that they're continuously learning from.

That there's not this, okay, we did it and now let's stop. It's a continual process of not only monitoring the measure, but monitoring how it's working in the field and is it really leading to improved outcomes.

You know, I think the attention on post-acute care and the attention on why the IMPACT Act is getting so much attention, is really tied up in the escalating costs. And the fact that there really is a lack of interoperability across PAC settings.

And I think that you all have been challenged with that with some of the measures. And I listened to part of your last conversation,

and even talking about medication reconciliation or pressure ulcers, and where is it most important, in a hospital or a home health, or where?

Well, wouldn't it be great if we all had the same measures and the same tools to assess that type of thing? That we could share the data whether it was a hospital or home health? And I think those are some of the -- you know, that's the direction that we're seeing going for the future. Next slide.

So, I think this just really kind of -- you know, it was a really nice visual that we got from our CMS colleagues. That really kind of pulled this all together.

That in order to achieve the goals, such as reduction in provider burden, measures that follow the patient, assessment of quality across settings, you really do need data uniformity and interoperability.

And as we've seen measures coming through the person- and family-centered care CDP

process, that's really what we're seeing more of, is that overall intent and it's even a guiding principle that we're taking back to the standing committing and reminding them, you know, this is the reason why these measures are being put forward. This is the reason these measures are being evaluated, and this is the overall intent of being able to have and close that gap. So that there's the opportunity to use measures and tools across settings. Next slide.

And you know, again, I think just another summary slide that brings us all back to the fact that when you look at the IMPACT Act, you look at the work that the person- and family-centered care standing committee is doing. And then you look at the National Quality Strategy.

They kind of -- they all go hand in hand on strengthening person and family engagement. And really the only reason -- the only way -- some of the ways to do that would be promoting effective communication and coordination of care of prevention and treatment

of chronic disease. And that's really about looking at the whole person through their whole treatment setting, through their whole episodes of care versus isolated measurements. Next slide.

So with that, I think, Megan, I turn that back over to you. Unless there are any questions on the work of the person- and family-centered care committee.

MS. ANDERSON: That's correct. I am going to turn it over to my Co-Chairs to facilitate questions for you, Sarah.

CO-CHAIR HANRAHAN: Any discussion? Tom?

MEMBER LUTZOW: Well, the IMPACT Act is refreshing and this approach is promising, and you know, godspeed.

I've always frankly been disappointed with the IMPACT Act. I feel like chopped liver when I read the IMPACT Act. Nowhere in the IMPACT Act is there any mention of the role of managed care or the plan. Even though it is a

key measure weighted three times in the group that -- the five star group that grades managed care.

So, somehow it seems to me that since plans are also responsible for this measure, that they need to be at the table. As it's set up, it appears to be only provider-focused coordination. And because it doesn't include plans which now enroll 30 percent of the population or better, it may not include a key player.

So, as you develop measures, you know, if this has only a fee for service focus, fine. But, the fact of the matter is, plans are measured on readmission and they need to be at the table.

MS. SAMPSEL: Thank you. You know, I just want to comment on that because that's one of the things that the person- and family-centered care standing committee, that's some of the feedback that was provided to CMS in consideration of the measures related to the CARE Items Set, is that those are specific to

Medicare. And you know, while there's setting of care there, then you know, you include only Medicare patients.

And so that was some feedback that they'd like to see the population broaden and the ability to use the measure by other settings of care.

That I just think that was outside the scope of CMS for that development cycle.

CO-CHAIR HANRAHAN: Clarke?

MEMBER ROSS: Hi Sarah. This is Clarke Ross. I wanted to ask you a question about the charge of the person- and family-centered care committee. And if I'm correct, then ask you about timeline.

So, is this the National Quality Forum committee that's considering the Medicaid home and community-based experience survey?

MS. SAMPSEL: It is. And thank you, Clarke, for bringing that up. So that is one of the measures that's in phase three.

MEMBER ROSS: And then do you have a

timeline for the committee's considerations, CMS submission and then public comment?

MS. SAMPSEL: Yes. So, we have -- and actually that was really a nice segue of something I forgot.

So, the measure submission was March 31. So, we have the measure in-house. We're currently CDP side in the completeness check and preliminary assessment phase.

And then in, I believe it's May 9 -- and I'll have to get back and I can let Megan know when that is -- but we'll be opening that measure set up for pre-evaluation public comment. So, those will be any comments you want the committee to have during their in-person meeting.

And our intent was to notify not only this committee through Megan and Debjani, but also the home and community-based services committee that is -- or a workgroup that's within NQF as well. To be able to get you all the project alert when those measures are available and open for public comment pre-evaluation.

The standing committee meets in-person in D.C. on June 6 and 7. And then that report and their preliminary recommendations will go out for public comment, and I would assume that's sometime in mid to late June.

MEMBER ROSS: Thank you.

CO-CHAIR HANSEN: Sarah, this is Jennie asking a question relative to whether phase three is going to look at the gap area or begin to document the gap area of pulling out really what matters to the person?

I know this is kind of the -- you know, the new areas because of the ability to make sure that that is part of it as the patient- and family-centered care side of it too.

Currently none of our measures more or less will capture that element. So, here we have outcomes that we think, you know, professionally should be able to be achieved, but how does that copacetically align with what matters to the person?

MS. SAMPSEL: Oh, that's such a good

question. You now, yes. In some, there will be a couple of opportunities.

And in all honesty, we've already heard that from the committee. We heard that -- and my phases start getting confused, but I believe it was in phase two that we had some discussion with the committee kind of off the record. So, it wasn't transcribed.

But, kind of what do they want to see? And what would really make a difference for them? And that really was about that integration of, okay, you say these measures are person- and family-centered care, but what do we know from the patient?

And so, you know, that conversation started with experience of care and we're seeing the committee push on that more and more and being able to put in our report the documentation of that push.

And I think there's going to be some opportunity to even further that conversation because we have two measures coming through this

third phase of work.

One is on the shared decision-making process and then the other has to do with -- again, with informed consent, shared decision-making, and the level of knowledge of patients for elective surgeries, specifically in knee and hip replacement.

So, you know, so that conversation will happen as part of those measure reviews. Those are measures that have been submitted by Jack Staller from Healthwise and Karen Sepucha from University of Massachusetts.

And then the other thing that I will just mention here is NQF -- and you can find this information on our website -- was funded by the Moore Foundation to do some work on shared decision aids.

And we're still kind of fleshing out what that looks like, but we've put together an expert panel that will convene also in June to talk about, you know, what would a shared decision aid certification process look like

where we'd be certifying the shared decision aids. And ensuring we have that patient value feedback, et cetera, as part of the decision aid certification?

Which is why we have people such as Karen Sepucha on the committee. Who feel very strongly about that portion of it.

So, I think we're getting closer and closer to having, you know, kind of concrete discussions about that gap and how we integrate it into our criteria, but, you know, I still think there's work to do.

CO-CHAIR HANSEN: Thank you, and I hope that some of the work that's happening at NCQA on their measure development with the grant from the SCAN Foundation is a part of that as well.

MS. SAMPSEL: I wasn't aware of that, but I can certainly follow up since they are my former employer.

CO-CHAIR HANSEN: Okay. Thank you. Charlie?

MEMBER LAKIN: Thanks. Thanks Sarah. You know, I read your definition with interest and noticed that -- I wasn't too enthusiastic until I got to the very last phrase that said respectful of and responsive to an individual's priorities, goals, needs, and values.

And you know, I think that's really what it's all about. People having control and choice and independence and relationships and self-determination, and for the 40 percent who are under 65, employment and housing. And I just didn't see those themes coming out as strongly in your presentation as I think they're felt by the people who are really interested in having person-centered and family-centered care.

And so, it sounds like you're really listening to people, but you're going to get an earful when you do, about the differences between what they can expect and what they're getting. Or what we would hope they might get -- what they would hope they would get and what they're getting.

So, you know, and even issues like shared decision-making. I think you get a lot of push-back from people about whether the decisions that affect their lives deeply are ones they really want to share equally with people and ones they really want to control personally.

So again, I'm excited about the title of this MAP. I do hope it can really listen carefully to people. The same people that sort of shape the HCBS regs, which I think are very forward looking, and also a lot of the people who speak quite lively on the HCBS NQF committee.

MS. SAMPSEL: Yes. You know, and I'll just comment on that. We had a few open slots on the person- and family-centered care standing committee and we focused really heavily on ensuring that we had more patients and caregivers on the committee that, you know, we have representation from MDs and OTs and nurses, et cetera. That we really wanted to do some strong patient focus.

So, we really beefed up the committee

on that respect in order to get more of that information out. And NQF, you know, it's challenging for us because then that means, you know, we may have people on our committees that don't understand reliability, validity, et cetera, but do patients' care.

And then, you know, I think the other piece that I'll mention on that, that's exactly one of the reasons why we want to ensure with this next phase of work that we notify both this group as well as the HCBS NQF Committee, that these measures are out for comment.

And I agree. We're going to get a lot of comments. We got a lot of comments in phase two. I think the most comments NQF has ever received, and we know it's important. And I think, you know, I would even say our definition of person- and family-centeredness and how that is interpreted under the criteria will most likely evolve over time.

CO-CHAIR HANRAHAN: Thank you.

MS. ANDERSON: Thank you, Sarah. This

is Megan. We are going to start the review of the measures that have been newly endorsed under this project and we thank you so much for your presentation. We hope that you can stay on the line to answer any additional questions, but understand if you have other obligations.

MS. SAMPSEL: No. I'll stay on, Megan.

MS. ANDERSON: Great, thanks. So, we are on slide 108 for those who are on the phone or elsewhere. And we're going to move on to slide 109 which lists 12 newly endorsed measures for consideration.

If you recall, we already discussed two measures that were not considered really the best in class for the population, and those were 2643 for lumbar spine and 2653 for total knee replacement. They were considered condition-specific and did not address the workgroup priorities.

So, in front of you, you have 12 newly endorsed measures for person- and family-centered

care project and we'll consider them one by one.

I'm going to go through each of them and pause for questions at the end. And based on that, at the end of this presentation, we will ask workgroup members to nominate a measure for inclusion in the family, if any at all.

Any questions?

(No response.)

MS. ANDERSON: Okay. Moving right along to 2287: Functional Change: Change in Motor Score.

This is a change in risk scored derived values of motor function from admission to discharge among adult inpatient rehabilitation facility patients aged 18 and older who are discharged alive within 12 -- and the time frame of the measure is 12 months.

It includes specific FIM items. And they are feeding, grooming, dressing upper body, dressing lower body, toileting, bowel, expression, memory, transfer bed, chair, wheelchair, transfer toilet, locomotion and

stairs.

It's a risk-adjusted outcome measure and it's classified for inpatient rehabilitation facilities.

The staff preliminary analysis consider it an addition to the family because it addresses high leverage measurement opportunities for quality of life and priority area in optimal functioning, and any questions about this measure?

MEMBER ROSS: This whole list of measures in some way seems to be contradictory to the purpose of the IMPACT Act, which is a single assessment, a single measure across facility and provider types.

And yet we're being asked to consider motor scores and inpatient rehab facility for patients between the ages of 18 -- or over the age of 18 and then each one is going to be setting specific.

And I know the expertise of the post-acute care and long-term care committee are

predominantly the four provider types.

But, this whole host just seems to perpetuate distinct provider types rather than making more significant progress in applying the same motor score across nursing homes, post-acute care settings, inpatient rehab settings, and home healthcare settings.

So, I'm already uncomfortable with the whole list because it's setting specific and the IMPACT Act's intent is to boldly go where we haven't been before across settings.

MS. ANDERSON: We don't have authority to make recommendations about the IMPACT Act. We're here to make recommendations to CMS and the Center for Medicare and Medicare Coordination Office.

We do have a representative on the phone still if they -- if you have a question specific to them. I think your point about this being a single setting measure is very valid.

However, it is not included at this time in IMPACT Act measures or any federal

programs. When a measure is included in a federal program, we will list that as well.

CO-CHAIR HANRAHAN: Michael? Or I'm sorry, Marcia.

DR. WILSON: Sarah, I think you're still on the phone. This is Marcia, and I'm going to start an answer, but please correct me if it's not correct.

I think part of what you're seeing, Clarke, is when a measure's brought forward for endorsement, the setting is specified. And so for example, some of these measures, I believe, Sarah, if I'm remembering correctly, had only been tested in the inpatient rehabilitation facility setting.

But the measure developers were very clear, is they intended to test them in further settings. So, I think, in part -- not the whole list. It doesn't explain the whole list, but I think in part, what you're seeing Clarke, is the beginning of a measure tested in one setting. With the intent to expand it to other settings.

Sarah, is that a fair statement for some of the measures?

MS. SAMPSEL: To some degree. What I want to delineate is the fact that the use of the word measure -- and so the FIM historically, and I believe has been fully tested and vetted in use across settings.

When we come down to the performance measure, which is under NQF's purview, so 2287, 2286 and 2321, those are the performance measures. And those were only put forward to us for the specific setting of inpatient rehabilitation facility.

And then so, you know, where I would say there are similarities is the CARE Item Set and the FIM item set are both, you know, as functional measures, are applicable to multiple settings.

When it came to the performance measures, those were submitted to us as Marcia said, on the endorsement side for specific settings.

DR. WILSON: Thanks for the clarification, Sarah.

MEMBER MONSON: So, this maybe just a -- this may be a total wrench, but, you know what? It's interesting because when I think about functional, I think about ADLs. Which clearly are -- some of them are listed here.

But, I don't think about them from a rehab/FIM perspective. And if -- I might be over my -- excuse me, but I'm pretty sure a FIM has to be done by a physical therapist or an occupational therapist. I don't think --

MS. SAMPSEL: That's correct.

MEMBER MONSON: So, there is a part of me that says -- you know, and I know that you started on post-acute. But, those same ADL measures, we're going to want to measure for Medicaid beneficiaries in the community and in long stay settings and facilities as well.

And is there benefit then to be thinking about how we actually measure ADLs that doesn't require a clinician to make that

measurement?

CO-CHAIR HANRAHAN: I'm still not really quite understanding Clarke, what you're trying to point out and I want to.

MEMBER ROSS: I'm trying to point out that there is a theme within the National Quality Forum to have fewer measures than more measures, and at the same time, we have 12 measures that are distinct to specific settings.

And the IMPACT Act's entire purpose is to have single measures and -- start it with assessment, but single data and single measures across settings so that wherever you go as an individual person, you have the same expectation, the same data, and the same assessment. And this seems to just contradict that.

And meanwhile, there's this -- we've got to have fewer and fewer measures. And yet, we want to add 12 that -- or consider adding 12 that are, again, distinct to one setting.

And I'm sure each of these has value. It's just why -- and the answer I heard was

because measure developers and each of the associations of these providers have these.

But how do a consumer representative think about and deal with and vote on this dynamic? Which I just -- I think this is the wrong direction to go, and yet you can justify the importance of each of the 12 areas to be measured.

MS. SAMPSEL: So Clarke, Marcia and I are arguing online who should answer the question for you. But, I'll just comment on that because I think it's a really important conversation for you all to have and for us to get this feedback on. And I think, you know, Megan and Debjani would agree that it's, you know, kind of getting there on the table is important for NQF for documentation purposes.

And that doesn't differ from conversations that we're having on the endorsement side. So on the CDP side, where there really is a hope and a try, I would say, to get standing committees to think about the

overall portfolio and do we need 12, and frankly I would envision there's probably a good 20 more functional status measures that their only difference is setting of care, where the tool is the same across settings.

And when it comes to the performance measure and number of actual performance measures, it gets to the conversation of okay, so which is the best performance measure?

And, you know, on the endorsement side what's brought to us would be the testing of how these performance measures play out, how they contribute to quality of care, and when you play instrument against instrument, there's obviously a lot more data in an instrument such as the FIM that's been out for 25 years, versus the care tool, which has been tested, which is being solely implemented, but frankly there's not enough data to say whether that's a good -- that tool's better than the FIM, et cetera, although obviously that's the hope.

But it raised a level of discomfort

even on the endorsement side to be able to say this measure is better than this measure. So, this is kind of back to I feel like a theme I said earlier, that this is an area of more to come where we need to listen to you all.

I think this really plays into part -- you know, what do patients and, you know, persons and caregivers want on this side as well? We're considering burden and how does this all play out, and how do we bring all this information together to not only bring back to groups such as the duals group, but the PAC/LTC, the overall MAP considerations, and then the endorsement process as well.

So it's not an easy answer but what we will say is that it's a consideration and it was also a level of challenge on the endorsement side.

MEMBER CHALK: So if we were to approve these, endorse them rather, what's the incentive of going to what Marcia said earlier? What's the incentive for a developer to take it

to then test in the all the other settings to make this an across-setting measure?

You said, you know, more to come. Maybe they'll test it in other settings. What direction is NQF able to give a developer, if any, about, this isn't where measurement's going?

It's not going setting by setting, and it's incumbent upon you, if you want to get our endorsement, to test it across settings and come back when you're ready.

DR. WILSON: This is Marcia. I would say that measure developers have already signaled to us that that is exactly what they want to do. And it's not so much NQF driving this, it's the IMPACT Act and where CMS wants to go.

MEMBER CHALK: But, that doesn't show up in the measures that you're asking us to endorse.

DR. WILSON: That's right, and because of what Sarah said, it's -- I don't want to say it's a temporary situation but it is somewhat a temporary situation where you have a -- say an

instrument like FIM that's been in use for a long time, CMS has developed the care tool.

And in bringing both of those forward, it was -- the committee was unable to say this is the best in class in terms of the measure, and so what happened is we asked for more time to let the care tool be tested.

We've had discussions with CMS and the developers of the measures from the FIM tool, and then the developers from the CMS care tool, brought them all together and say, we're going to watch this and come back at a point in time to see what happens.

So I see this as an interim step to getting to where we want to go. But it does, I will admit, it poses a dilemma for this workgroup right now at this point in time.

CO-CHAIR HANRAHAN: Go ahead Tom.

MEMBER LUTZOW: Yes. I'm getting the sense that CMS needs these endorsed to create an environment for them to move ahead. If I'm wrong, that's fine.

The assumption is that achievement of high scores in each one of these measures somehow serves the purpose of readmission prevention.

And do we have evidence that that is the case? Or are we simply creating an environment where that will be perfected later, but now CMS can move ahead because NQF has created an endorsement set that serves as a foundation for them to act? I mean, is that what we're talking about?

MS. ANDERSON: Well, from a --

MEMBER LUTZOW: So, I have two questions. Does CMS need us to do this for other reasons, to build an assessment program that serves the purpose of readmission prevention?

And then do we have evidence that this truly does serve to strengthen readmission prevention?

MS. ANDERSON: Some measures that are in front of you from the person and family-centered care project are primarily related to functional status. And they are elevated to this

discussion and this intensity because it is a priority gap area that this workgroup has voted as a priority.

And so optimal functioning is one of the highest priorities from this workgroup's perspective. CMS has not asked, and this is not part of our contract with CMS, is their funding to review these measures other then in to maintain the family of measures.

And that the work today is not directly related to input on the IMPACT Act and federal programs for post-acute long term care settings. It is directly related to the dual beneficiary population, which happens to also have a high utilization rate of post-acute and long term care settings.

So, I don't know the -- I think there's probably somebody who's smarter about functional status measures and readmission. But these measures are about functional status, and we're not being -- we're not under any directive from CMS to look at these measures.

And if you -- if the workgroup does not think any of them should be included in the family, none of them need to be included in any way.

MEMBER LUTZOW: Yes, in my view, the concern here, and the specific reason the duals are at a little bit of at a disadvantage on readmission prevention, I would guess the rate is higher, I'm sure it is higher with duals, is really the home environment.

You have infection control issues, hygiene control issues, fall risk control issues that are really part of their domestic environment. And that environmental assessment and correction is where some of the major work has to be done for us to bend that curve.

So, you know, getting to that home environment and supporting a correction there, is kind of a key intervention strategy here. So, that part seems to be missing.

MS. ANDERSON: So I think you're going to hear tomorrow from one of our colleagues from

NQF about the home and community service project and the environmental scan that's been conducted and input from that committee.

We're also going to have a significant focus tomorrow afternoon on community integration connection to community resources, which is strongly related to things in the home that you're talking about.

So that would be things we can look forward to tomorrow, though I definitely understand the connection to the functional status measures that are in front of us, and readmission rates and the importance of the home environment.

And so, this is really interesting conversation. I think that we'll continue to hear it and it will be one of the primary themes for our report.

CO-CHAIR HANRAHAN: I'd like to add to something Michael said that I wouldn't have identified. But, I think his -- as problematic as this being site sensitive or specific is the

FIM being only valid if used by a physical therapist. And I think you said it too, Clarke that you know, if it's provider centric, and the measures are provider centric, how does that move this agenda forward?

The other is, you know, I think many of us are familiar with the MDS, which is a great data system and a database that measures functional ability very well, and we've got huge longstanding data for good comparison and good risk adjustment and et cetera, et cetera. Has the MDS been considered? And why the FIM? I know why the FIM. It's got probably some validity studies that make it endorsable, but --

MS. ANDERSON: We're going to see some MDS measures that are related to the care tool next, but I think we have one more question related to this conversation and then we can move on to discuss the care tool measures and that MDS data. Does that make sense for the workgroup?

Okay. Alice?

MEMBER LIND: Actually I was just

going to say, could we go back to the long list and just focus on the couple that you picked? And skip -- not go through in such detail all the ones that you don't really like? So -- but you didn't really prioritize the care ones either.

MS. ANDERSON: It's not that I didn't like them. It's that --

MEMBER LIND: Well, the fit. I mean, right? You were looking at them for fit. And it's like it -- I mean, I'm just thinking if Thomas and Clarke both don't like FIM measures, let's just get to the ones that you think there's any promise of us choosing and not belabor it.

MS. ANDERSON: With all of these measures, they are new measures. They're newly endorsed, and most of them are newly developed in any way. And so, we have a challenge with any experience with these measures. And so, there -- it's hard to bring anything to the top.

And so, from the staff analysis perspective, it could not weigh any of the measures -- hardly any of the measures above

others, except for those that truly rose to the top. And there is a specific challenge in weighing care tool measures over the FIM measures because of the newness of them. And so -- and of the comparability. The standing committee couldn't pick them so, as staff, I'm having a hard time also picking.

So, are others in favor of looking at the staff picked measures 2624, functional outcome assessment, and 2631, percent of long term care hospital patients with admission and discharge functional assessment and care plan that addresses function?

Are you interested in looking at those two in isolation? And waiting for more use data and information -- experience information about the other measures before recommending them for use in dual beneficiary populations?

I'm seeing a lot of nodding heads. We have one more question. Michael?

MEMBER MONSON: Actually it's a comment more. Which is under -- I would -- I understand

where these new measures came from. I would recommend we not spend a lot of time on ERTH and LTC measures. Only because they're dinosaurs that -- you know.

And the way the policy environment is going -- and not that there's not a place for them, but there's not going to be a lot of place for them actually with the way the policy and payment environment is going.

So, spending a lot of time figuring out measures for settings that are effectively going to be far and few between if existing at all, it doesn't seem necessarily like the best place for us to spend our time.

MS. ANDERSON: Okay.

MEMBER ROSS: I'd just like to reinforce that site-neutral payment is a big issue pushed by Congressional committees and MedPAC and people within CMS, and so each of the distinct provider groups are resisting site-neutral payment.

But if that happens, what Michael just

said is going to happen. And so --

MEMBER ANDREWS: I would recommend, in light of this discussion and that, you know, the measures 2624, it doesn't -- it essentially says outpatient care. And outpatient care can be home care, it can be any type of rehabilitation outcome, function-related assessment.

And again, I would disagree a little bit with Michael in terms of, you know, the acute rehabs and long term acute care is going to go away because you can't really do away with it unless you have another provision for where that care is going to be given.

As we started to push and move inpatient care to the outpatient, a lot of that extra cost moved, and needs, to the outpatient setting. So, and if you have it at home in the home setting with the right environment to support that care, then that would be fine.

But again, we can't just say it's going to go away. So, again, I'm going to back and recommend that we look at 2624 as an option

for endorsement.

CO-CHAIR HANRAHAN: I think that's -- I think we need to do that also, just to complete for the day. And duly noted that these measures will change in time and the circumstances.

MS. ANDERSON: Okay. So, we're going to look at slide 113, and the measure number is 2624 and the title is functional outcome assessment.

It's a percentage of visits for patients age 18 and older with documentation of current functional outcome assessment using the standardized functional outcome assessment tool on the date of the encounter and documentation of a care plan based on the identified functional outcome deficiencies on the date of the identified deficiencies.

It's a risk adjustment outcome measure specified for ambulatory care and outpatient rehabilitation facility analysis, and it's collected through administrative claims and medical records.

The staff preliminary analysis is to consider for inclusion in the family and addresses a high leverage opportunity for measurement of quality of life in priority gap areas in goal-directed, person-centered care planning and implementation and optimal functioning.

I would note that there are a couple of exclusions. If they -- if a patient refuses to participate and if the patient is unable to complete the questionnaire, or if there's an urgent medical situation that would delay treatment and jeopardize the patient's health.

Go ahead.

MEMBER ANDREWS: I do have a question on this one. Does the measure allow for, or does it incorporate, an expectation of improvement as far as outcome measurement?

Or is it just an assessment?

MS. ANDERSON: It is an assessment. It is an assessment and a care plan based on the assessment.

CO-CHAIR HANRAHAN: It's a zero one. Yes or no.

MEMBER ANDREWS: That doesn't make me feel good.

MS. ANDERSON: And the reason it is staff picked is because it includes that care plan element. And we've heard that from the core group before.

MS. SAMPSEL: Megan, this is Sarah. This is not an outcome measure. It's a process measure.

I just wanted to clarify that. That's where that question may be coming from. But this is a process measure.

MS. ANDERSON: Sorry for the typo.

CO-CHAIR HANRAHAN: Gwen?

MEMBER BUHR: So, is this saying that every time you see a patient in the office you have to document a standardized functional outcome assessment? It seems like you wouldn't have to do that every time you see somebody in the office to me if they're the same as they

were.

MS. SAMPSEL: The measure is looking for a current functional outcome assessment, so it's not specified as every office visit.

MS. ANDERSON: And I'll also note that it's in PQRS with the newest available information. It's in PQRS.

CO-CHAIR HANRAHAN: Tom?

MEMBER LUTZOW: Yes. This is more of a factoid. The impression is that this is agnostic with respect to what functional screen is used as long as it's an IADL focus.

And right now the MDS does have that component and so does OASIS, the tool used by home health agencies. And in fact it's a measure within the five star program for plans.

So, CMS actually allows us to upload that content from MDS and the content from the OASIS and load it into our case record, and it counts as our function and screen. They just need it to be done.

I presume that that would also be true

in PQRS as long as it's current, it's done by somebody that's qualified to do it, and it doesn't need to be redone by the physician to count, as long as it's done.

So, is that part of the understanding here that we're talking about an agnostic across system function that, you know, MDS doesn't need to retool here and neither does OASIS? We're not asking anybody to retool anything.

MS. ANDERSON: Sarah, do you have any information about the data source specifications?

MS. SAMPSEL: Yes. I mean, this is a -- as you mentioned, it's a PQRS measure. So, this measure is a claims-based measure. It's not using OASIS and MDS. So there are G-codes that are applicable to this measure, and, you know -- in order to pull documentation out of medical records.

MS. ANDERSON: Mady, you had something. Did you want to go to a vote? You don't want to go to a vote? Are you ready to go to a vote Mady? Okay. That's what I thought.

Okay. Well, that's kind of what I need as a staff member, is someone ready to go to a vote and nominate for inclusion in the family. Is that what you would like to do? Or is there anyone who would like to vote for this measure?

MEMBER ANDREWS: Is the vote to consider this one only for a yes/no? Or is the vote to want this one and then we go to the next one?

MS. ANDERSON: Correct. Now we are voting on 2624 and then we will discuss another measure and vote on that separately.

Okay. So, the --

MEMBER ROSS: I don't know if Mady was joking or not, but when we first started this conversation she said, why don't we vote the whole block?

Are the entire block helpful to people who are dually eligible or not? So, if you are attached to one or two, then we'd have to proceed one by one. But -- so were you serious? Because --

MEMBER CHALK: I was serious.

MEMBER ROSS: Okay. So maybe an alternative vote is this entire 12 list helpful right now --

MEMBER CHALK: In its current form.

MEMBER ROSS: -- in its current form to people who are dually eligible? Yes or no?

MS. ANDERSON: So, the inclusion of 12 additional measures into the family that already includes 76.

I'm standing between you and dinner.

(Laughter.)

MS. ANDERSON: And I am happy to take a nomination to conduct that vote. Our Chair is not quite convinced.

So, we have one vote nomination on the table which is to include -- and so we have to think about the message that we are sending to CMS about the support of measures for inclusion in the family that are intended to be the best available measures for dual eligible beneficiaries.

And there are 12 measures here on functional status which have been newly endorsed. And would -- is the workgroup intending to say that if we include these 12 measures, we will have fulfilled this gap and we can cross it off the gap list, and we have now 12 additional measures that CMS needs to continue to prioritize and continue to contend with for the use in dual beneficiary population.

MEMBER LIND: Isn't what you mean, is like the vote is either any or none? And so vote yes if you want any of them considered. And then we'd have to take them one by one.

And vote no if you say no to the whole bunch. Right? Isn't that what you're leaning? Yes. It's more of leaning towards a no to all vote. Not a yes to all vote.

MS. ANDERSON: Okay. This is a new option. And so we're going from looking at the staff picks to looking at all of them together and voting on do not include any of them in the family. Okay.

CO-CHAIR HANRAHAN: Not or --

MS. ANDERSON: Do not include any of the 12 newly endorsed functional status measures in the family. And so we --

MEMBER DUNFORD: This is Jim. Would you guys -- is there a way to say, I mean, is there an existing gap that any one of these fills?

Or are there gaps that we've previously identified that require all of these to fill? Just from the staff point of view and your analysis of this. I wouldn't want to add 12 myself in a wholesale addition without knowing a whole lot more about every one of them.

But, I mean, is there a gap that we should focus at?

MS. ANDERSON: A gap? There is, one of the six -- seven priorities gap areas in the family is optimal functioning.

And so two of the measures seem to have addressed functioning from the staff pick level, though all of the measures in front of you

address function.

CO-CHAIR HANRAHAN: But there's also -- there's 2286 and 2321 both do the same as the one that you selected, functional outcome assessment. Now I'm not sure what the difference is.

I guess, you know, I'm not sure if we vote en block to include these. Does that -- what does that mean? Is it -- it is going to go to CMS and they're going to say NQF endorses all these measures, so we're going to implement them?

MS. ANDERSON: So these measures have been already endorsed. The recommendation from this workgroup to the Medicare and Medicaid Coordination Office would then be to -- support of all of these measures in the use -- for dual beneficiary populations.

And if that is the intent of the workgroup, then that is what we should vote on. Or do not support any of these measures for use in dual beneficiary populations while the optimal functioning gap still remains open.

MEMBER RASK: To your question that the 2286 is only people in an inpatient rehab facility. So, it is the same limits as those other ones. I thought it was -- problem is when I looked there too, I -- what I'm sort of -- if I was interested, as I'm thinking about it, interesting for dual eligibles, I'm interested in the ones that -- I'm less interested in some of these very facility-specific ones.

I feel like they don't necessarily need to jump in and be used. But the 2624 that at least is more of an outpatient, more generic, that seems like a reasonable -- giving us something in the functional assessment area that might be applicable to a broader group of dual eligibles while these other very specific ones, save them for another day to see if we really have a gap in that particular area that needs to be filled.

MEMBER CHALK: And by the way, in my slide deck that I have here that was sent, there were two 2686 measures. One says inpatient rehab

facility. I can show it to you. It's on my slide deck. And the other one says it's been specified for all kinds of other settings. So, which one is it?

MS. SAMPSEL: So, this is Sarah again. 2286, 2287, 2321, they are all specified at the level of the inpatient rehabilitation facility.

MEMBER RASK: So, I would like to make a motion that we consider individually 2624.

MS. ANDERSON: Okay. So I think we have the slide ready to vote on 2624, and this is the inclusion of a single measure into the family, and it is the functional outcome assessment.

Again, a reminder, this is a standardized functional outcome assessment tool and documentation of a care plan based on the deficiencies, and it is a risk adjusted process measure for ambulatory care and outpatient settings, and it is in PQRS.

We've had a lot of discussion since we went over that so point your clickers at Janine

and she will let you know what's up and down.

MS. AMIRAULT: Okay, so for measure 2624 on being added to the family of measures, one being yes and two being no.

(Voting.)

MS. AMIRAULT: Okay. We have ten yes and six no, and based on the percentage of 63, this is in consensus to be added to the family.

MS. ANDERSON: Thank you. So we have added 2624, functional outcome assessment, to the family of measures for dual beneficiaries.

And we will move on if we have another nomination for inclusion to the family for the staff pick of 2631. I heard that before. Does that stand?

Alice, do you still want to nominate 2631 for inclusion in the family? The staff pick?

MEMBER LIND: I don't want to nominate any of these other measures.

MS. ANDERSON: Not the staff pick though? No? Okay. I misunderstood.

Would anyone else like to nominate any of the other measures for inclusion into the family of measures?

(No response.)

MS. ANDERSON: Okay. I am understanding that as -- then that the gap continues to persist in the family of measures of optimal functioning. While this measure is a start, and we will continue to observe the development and implementation of the remaining measures, and as that information becomes available, bring it back to this workgroup for consideration and recommendation. Okay.

So, it is about time for public comment. Unless there are any other thoughts? Okay.

Operator, can you please open it up for public comment? And other than the room, if there's any public comment, and Janine, whether or not there's any comment in the chat.

OPERATOR: At this time, if you would like to make a comment, please press star then

the number one.

(No response)

OPERATOR: And at this time there are no public comments from the phone line.

MS. ANDERSON: Thank you very much. I'm going to turn it over to Janine to give us a little bit of a reminder about our plans for this evening.

MS. AMIRAULT: Hi everyone. So yes, just as a reminder, we're going to be doing dinner at Georgia Brown's at 6:30 tonight, so I guess -- it's close by. And we can send the address if anyone doesn't have it.

MS. ANDERSON: If you walk out the main lobby of this building, and you go right, it is across the street. And if you are at the hotel, you also go right, and then you go right again. It's around the corner.

If these -- for those workgroup members, please keep your receipts. This will be individualized receipts and you'll submit them to NQF with your other reimbursement information.

And we look forward to seeing you this evening for those of you who can make it. And for those -- for all of us, tomorrow morning breakfast starts at 8:00 a.m.

It's continental breakfast similar to today. We have a full day and the meeting starts at 8:30, in which we'll recap some of what we talked about today. Bring you perhaps two additional measures for consideration and talk about prioritization, then we'll hear about HCBS and the ongoing NQF effort to explore measures for HCBS. And we'll really delve into community integration and connectivity resources midday.

So, we thank you very much for your participation and attention today. And you get out 15 minutes early even though we're behind by 45 minutes today. So, congratulations. Good job.

(Whereupon, the above-entitled matter went off the record at 4:44 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Dual Eligible Beneficiaries W/G

Before: NQF

Date: 04-19-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter